

The 2004 Report to the Secretary: Rural Health and Human Service Issues

The NACRHHS

The National Advisory
Committee on Rural Health and
Human Services

April 2004

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Sincerely,

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About the Committee

The National Advisory Committee on Rural Health and Human Services (NACRHHS) is a 21-member citizens' panel of nationally recognized rural health experts that provides recommendations on rural issues to the Secretary of the Department of Health and Human Services. The Committee was chartered in 1987 to advise the Secretary of Health and Human Services on ways to address health and human service problems in rural America.

The Committee is chaired by former South Carolina Governor David Beasley. The committee's private sector and public sector members reflect wide-ranging, first-hand experience with rural issues - including medicine, nursing, administration, finance, law, research, business, public health, aging, welfare and human services.

The Committee is currently composed of 21 members, including the chairman, who serve overlapping four-year terms. The members represent expertise in the delivery, financing, research, development, and administration of health and human services in rural areas. Several members are involved in training rural health professionals. Others are representatives of state government, provider associations, and other rural interest groups.

Each year, the Committee produces a report for the Secretary on key health and human service issues affecting rural communities. Background documents are prepared for the Committee by contractors to help inform members on the issue. The Committee then produces a report with recommendations on that issue for the Secretary by the end of the year. In addition to the report, the Committee may also produce white papers on select policy issues. The Committee also sends letters to the Secretary after each meeting. The letters serve as a vehicle for the Committee to raise other issues with the Secretary separate and apart from the report process.

The Committee meets three times a year. The first meeting is held in early winter in Washington. The Committee then meets twice in the field (in June and September). The Washington meeting usually coincides with the opening of a Congressional session and serves as a starting point for setting the Committee's agenda for the coming year. The field visits include ongoing work on the yearly topics with some time devoted to site visits and presentations by the host community.

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Executive Summary

A New Focus

In the last year, the National Advisory Committee on Rural Health and Human Services has expanded its focus. Five new members who are experts in the field of rural human services have been added and the Committee is now charged with advising the Secretary of Health and Human Services on human service issues in addition to rural health issues. As a result, this year's Committee report does not focus on one primary issue as it has in years past. Instead, the 2004 Report to the Secretary opens with a general overview of some key current issues and trends affecting health and human service delivery in rural communities. This overview identifies several issues that may require further analysis by the Committee in future years. The chapters that follow focus on three key issues the Committee has chosen to examine on a more in-depth level. Those issues are:

- 1) behavioral health and primary care coordination in rural communities;
- 2) access to oral health care in rural communities and;
- 3) access to human services for the rural elderly.

Each chapter includes a summary analysis of the key issues in each topic area and a set of recommendations for the Secretary on how to address problems identified by the Committee.

Report Framework

The Committee chose these three topics for further study after hearing testimony from a range of health and human service experts at its Winter 2003 meeting. The Committee held two field meetings to learn more about how these issues affect rural communities. The first of these meetings was in Uvalde, Texas in June and the second was in Charleston, West Virginia in September. During those field visits, the Committee met with local leaders and visited local caregivers to gather information for this report.

Key Findings

- Rural communities would benefit greatly from **integrating behavioral health and primary care in rural settings**, but face significant barriers in doing so. Those barriers include reimbursement that is tied to particular types of service providers, restrictive State licensure practices that exclude key providers, institutional resistance toward integration and lack of integrated training curriculums, to name a few. The Committee recommends that the Secretary support efforts to reach mental health parity in coverage for Medicare and Medicaid beneficiaries and urges the Secretary to work with the Congress to encourage third-party insurers to do the same. The Committee recommends that the Secretary expand the range of certified mental health providers under Medicare to include marriage and family therapists, licensed professional counselors and other behavioral health providers that are licensed in their States to provide behavioral health services.
- **Access to oral health care services in rural communities** is very limited. Enhancements to current reimbursement methodologies are needed that will increase access and increase the number of providers willing to see Medicaid and indigent patients. The Committee noted that in 2001, 67.1 percent of urban residents had visited a dentist in the previous year, while only 58.3 percent of rural Americans had done so. Rural residents are also less likely than their urban counterparts to have dental insurance. There are also significantly fewer dentists in rural America. The U.S. average for dentists is 52.5 dentists per 100,000 residents. In rural counties there are only an average of 34.5 dentists per 100,000 people. The Committee recommends that the Secretary authorize an oral health bonus within the Medicaid program to encourage greater participation by dentists in serving this population. The Committee recommends funding increases for existing HHS programs that support either training or placement of dentists in rural com-

munities. The Committee also recommends that the Secretary work with the Congress to create a new program that provides funding to States for the fluoridation of small community water supplies and provides ongoing technical assistance and maintenance for such systems.

- **The rural elderly face significant challenges in accessing needed services** such as nutrition, transportation and adult day care. The Committee notes that rural Area Agencies on Aging often lack the necessary infrastructure to provide needed services, and the populations they serve are often geographically isolated and have higher rates of poverty and chronic illness. The Committee recommends that the Secretary develop and administer a demonstration project that would support innovative transportation projects for the rural elderly by coordinating with existing transportation services such as school buses and Head Start programs. The Committee also recommends that the Secretary support research to better understand how existing HHS programs serve the rural elderly.

Introduction

The Committee's New Charge

This report reflects the first product from this expanded 21-member Committee, which has added a focus on human service issues. For fifteen years, the National Advisory Committee on Rural Health (NACRH) advised the Secretary solely on the unique nature of health care delivery in rural America. In 2002 the Secretary, as part of the Department's Rural Initiative, expanded the Committee to also focus on human service issues and renamed it The National Advisory Committee on Rural Health and Human Services (NACRHHS) (see text box below). In its report to the Secretary, the Department's Rural Task Force noted the common challenges facing health and human service providers in rural areas.

The expansion of the Committee's focus is an important and critical step to take but also one that poses some significant challenges. While health care issues and human service issues are often closely linked and interrelated, they also represent two very different sectors. The Committee notes that as it accepts this challenge it is also important to understand that the infra-

structure for health and human services is not equally supported both within HHS and externally.

Rural America has had a specific point of contact at the Federal level for tailored health care delivery programs and policy advocacy through the Office of Rural Health Policy in HRSA for 16 years. The same, unfortunately, cannot be said for the human service sector. The programs and the focus tends to be more global, with rural as one of a number of distinct subpopulations within that larger universe. As a result, data and information specifically on rural human service recipients and programs often is not available. That, in turn, makes it difficult to understand the impact of Departmental policies and programs on rural communities. The resulting inequity of support, focus and analysis puts rural human service issues at a disadvantage, in terms of both Departmental infrastructure and expertise. The Committee believes the Department should take this into account and develop strategies to address it as the Secretary's Rural Initiative continues.

Despite these challenges, the expansion of the Committee is a wonderful opportunity. It affords a potential

The Secretary's Rural Initiative and Related Activities

Amid the changes and challenges of the last year, the National Advisory Committee on Rural Health and Human Services is encouraged by the continued efforts of the Department of Health and Human Services (HHS) to focus on rural concerns. The impact of the Secretary's Rural Initiative, which began in 2001, continues to yield benefits for rural communities. The issuance of the report that emerged from the initiative, "One Department Serving Rural America," marks the first time the Department has focused intensely on rural issues. In 2002, the Secretary made the Rural Task Force, which produced the report, permanent.

There were also several activities that began as a direct result of the Task Force's work. The creation of the Rural Assistance Center as a one-stop portal for information on rural issues continues to be a great resource. Likewise, the expansion of this Committee to include a focus on human services allows it to examine an even wider range of issues that affect rural citizens.

Still, the most lasting potential impact of the Secretary's Rural Initiative lies not necessarily in new programs or funding but in changing the fundamental way the Department conducts its busi-

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The Secretary's Rural Initiative

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ness. The early results have been promising. Thanks to the Secretary's continued interest in rural issues, the HHS agencies and staff divisions have begun to actively think about rural concerns. The Centers for Medicare and Medicaid Services' (CMS) have made perhaps the greatest strides. The Rural Open Door listening sessions, which CMS began holding in 2001, have allowed rural providers to address a range of regulatory issues that have been affecting them for years. However, rural providers continue to experience some frustrations in those situations in which they fall in between various rules and agencies. The Committee is hopeful that CMS will continue these Open Door forums.

CMS continues to include rural concerns in the policy-making process by having a senior administration official in its Central Office and a senior administration official in its Regional Office focus on rural issues. Both the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration for Children and Families (ACF) have made addressing rural concerns a priority in their strategic planning activities.

All of these are positive developments. In prior years, rural concerns were not always a part of the policy development process. Rather, these concerns were, at times, an afterthought. Now, some policymakers across HHS are asking about the rural implications of policy earlier in the stages of policy development and program implementation. The challenge for HHS lies in sustaining and expanding that orientation in the coming years. The Committee believes this is a critical need. It will be important for this Secretary to continue to make this a priority for the remainder of his tenure and for future Secretaries to continue that emphasis.

new voice for the rural human service sector to express its concerns to the Secretary and others. There are a variety of human service programs administered by the Department primarily through the Administration on Children and Families (ACF) and the Administration on Aging (AoA) that are vitally important to rural communities. Beginning with this report, the Committee hopes to examine key human service issues and provide recommendations to the Secretary that will help address rural concerns.

Rural America 2004: A Demographic Portrait

In the past year, a more current picture of rural America is emerging as more data from the 2000 Census is released. According to the Office of Management and Budget (OMB), there were 48 million people living in the 2,052 rural counties across the country in 2003.¹ This is an increase of 10 percent since 1990. In general, the largest increases in population are occurring in coastal areas. The West has experienced the largest growth while the Great Plains has experienced the largest decline.^{2,3} The emigration of younger people to urban areas combined with low immigration rates has resulted in an older population base in the Great Plains. Population loss also occurred in low-income rural areas, such as the Appalachian coalfields and the lower Mississippi Valley.^{4,5}

Additionally, while rural Americans are predominately white, there is significant ethnic and racial diversity in many rural areas. More than 90 percent of the African-American rural population resides in the rural South. The growth of the Hispanic population was concentrated largely in the Southwest and increased the most numerically.

Rural areas continue to face socioeconomic challenges. Non-metro counties continue to have higher poverty rates than metro counties. Approximately 14.2 percent of rural residents were classified as poor in 2001, compared to 11.1 percent in urban areas. Still, it is worth noting that those rates are lower than what they have been historically, especially compared to 1983 when the rates were 18.3 percent in rural areas and 13.8 percent in urban areas.⁶

Clearly, rural areas have many challenges. There is great variability across rural America within all of these demographic and socioeconomic realities. All of these changes have an impact on rural communities. They have an impact on children and families and the services they receive, from social services to education, especially given the dramatic changes of the No Child Left Behind education legislation passed by the Congress. The demographic changes also affect seniors, both in terms of accessing senior services such as Meals on Wheels or in obtaining services as Medicare beneficiaries.

Recent Key Policy Issues

In 2003, rural communities, like most communities in the country, were affected by a number of concerns including worsening State budget crises, a slowing economy, and ongoing worries about bio-terrorism. As these issues continued to evolve, several key policy issues were debated during the past year that had important implications for rural America:

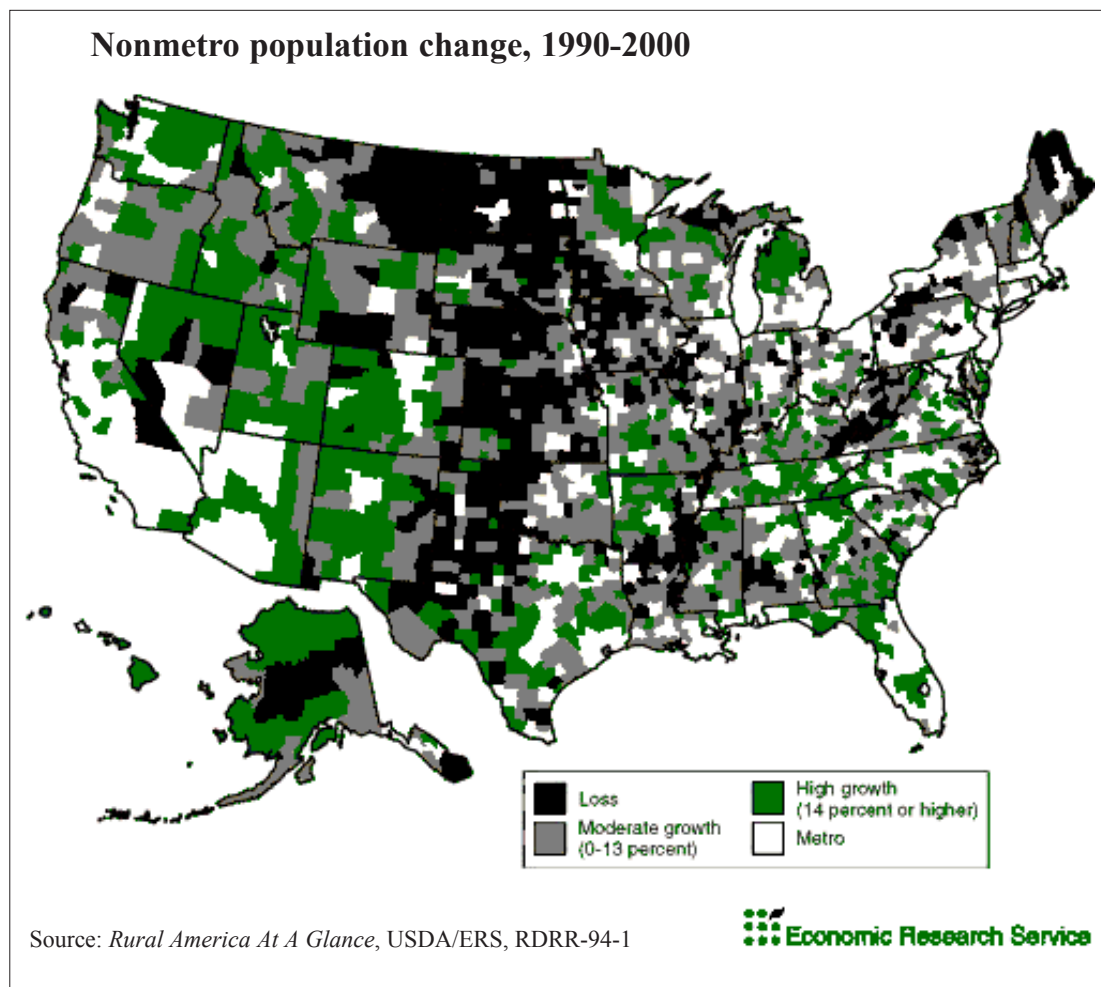
Medicare Reform

The Congress passed and the President signed into law P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which created a new prescription drug benefit for Medicare. This benefit is vitally important to rural Medicare beneficiaries who are more likely than their urban coun-

terparts to lack any kind of prescription drug coverage, either through supplemental plans or employer-sponsored plans.

The implementation of this legislation is a huge undertaking. The new benefit will challenge HHS as it seeks to increase access to pharmaceutical drugs while also keeping costs controlled. The Committee believes that policymakers will need to monitor the implementation of the drug benefit to ensure that it benefits rural communities. Since the legislation relies on private insurers to provide the drug benefit, this will be particularly challenging in those isolated rural areas where some insurers have not traditionally offered services. Policymakers should also monitor the impact of this plan on rural pharmacists, who play a vital role in rural communities.

The MMA included significant changes in Medicare payment policies designed to provide greater equity to rural providers. The lowering of the labor share portion of the Medicare Wage Index and the equalization of the standardized payment within the inpatient prospective payment system were key provisions for rural provid-



ers. The raising of the cap on Medicare disproportionate share payments to 12 percent is also beneficial for rural communities, but the Committee believes further action on this issue is needed. Rural hospitals should be treated the same as urban hospitals for purposes of this adjustment. Other changes in the bill related to Critical Access Hospitals (CAHs) also represent common-sense changes to Medicare policy. Still, the MMA did not address all needs. The Committee is concerned that the Congress and the Administration did not include correction to the payment discrepancies that would provide payment parity between Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). RHCs currently are paid less for the same services.

Welfare Reform

The Congress also debated but did not enact welfare reform during deliberations over the re-authorization of the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, the ground-breaking change in welfare law from 1996. Congress extended current

funding for the program through March 31, 2004, so this is likely to be a key issue for the Congress early in 2004. During the 108th Congress, both the Senate and House passed bills on this issue. However, consideration of Temporary Assistance to Needy Families (TANF) reauthorization, a key component of the welfare reform re-authorization did not reach the Senate floor. The TANF payments are critically important to rural communities to continue progress in moving rural residents off of welfare and into the workforce.

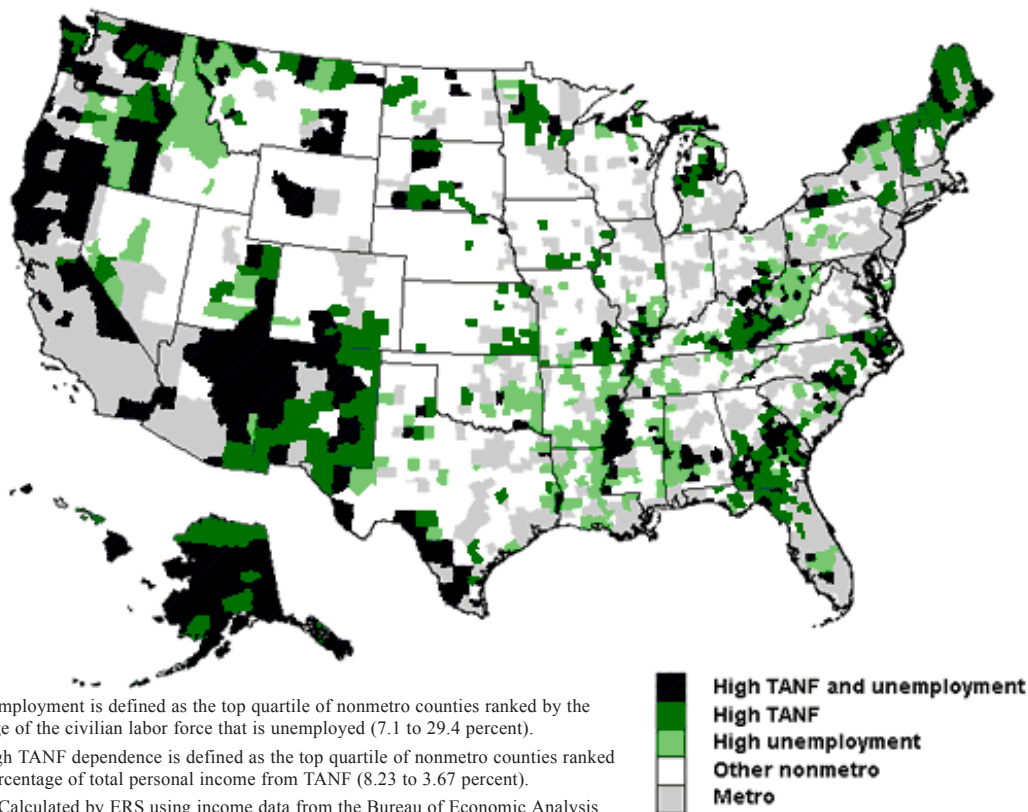
The Committee will continue to monitor this debate, which has tremendous implications for rural communities where caseloads are smaller and job and daycare opportunities may be scarcer for those individuals making the transition from welfare to work. This may make it more difficult for rural welfare recipients to make the transition to self sufficiency.

The Uninsured

In 2003, the number of Americans without health insurance continued to grow. While this is a problem across the nation, it appears to be more acute in rural areas.

According to the Kaiser Commission on Medicaid and the Uninsured, there are nearly 41 million uninsured in America and one in five resides in a rural area. Rural residents living in the most remote areas face higher rates of uninsurance than urban residents, 24 percent compared to 18 percent. Medicaid, State Children's Health Insurance and other public programs insure 16 percent of resi-

Overlap of high TANF dependence and high unemployment in nonmetro counties, 1998



Nonelderly Health Insurance Coverage, by County Type, 1998

	Private	Medicaid/Other Public*	Uninsured
Rural Non-Adjacent	0.60	0.16	0.24
Rural Adjacent	0.71	0.10	0.18
Urban	0.72	0.11	0.18

Source: Kaiser Family Foundation ⁷

MSAs have at least one urbanized area of 50,000 or more population, plus adjacent counties that have a high degree of social and economic integration with the core as measured by commuting ties. Micropolitan Statistical Areas have at least one urban cluster of at least 10,000 but less than 50,000 population, plus adjacent counties that have a high degree of social and economic integration with the core as measured by commuting ties. Most micropolitan counties would previously have been designated as non-Metropolitan areas. Counties not classified as metropolitan or micropolitan are considered non-Core Based Statistical Areas (non-CBSAs).

dents of rural counties, while only 11 percent of urban residents are covered by these programs.⁷ The Committee will continue to monitor the rural implications of this situation and urges the Department to do the same.

Emerging Issues in Rural America

While this year's report focuses on the issues of integration of primary care and behavioral health services, oral health access, and serving the elderly, there are a number of other emerging issues worth noting. The Committee seeks to bring these matters to the attention of the Secretary and other policymakers. These topics include new geographic standards used to define rural and urban areas; obesity and wellness; access to specialized health and human services; and health care cost shifting. Each of these topics may merit further attention by the Committee in future reports. However, they are also important enough to receive some brief attention here.

OMB's New Geographic Standards

This past year marked the introduction of a new way to classify geographic areas. In June of 2003, the Office of Management and Budget (OMB) released its updated statistical areas based on the 2000 Census data. This included a revised classification for rural and urban areas that was six years in the making. Prior to this, the primary geographic delineations were Metropolitan Statistical Areas (MSAs), which translated loosely to urban areas, and non-Metropolitan Statistical Areas (non-MSAs), which translated loosely to rural areas. To this mix, OMB added the new classification of Micropolitan Statistical Area.

tion with the core as measured by commuting ties. Most micropolitan counties would previously have been designated as non-Metropolitan areas. Counties not classified as metropolitan or micropolitan are considered non-Core Based Statistical Areas (non-CBSAs).

The Committee supports OMB in its efforts to refine these designations. It is also important to note, however, that OMB throughout this process recognized that its primary motivation for refining the designations is to improve statistical analysis. The reality, however, is that the OMB geographic standards are used for purposes well beyond statistical analysis. Many HHS programs use these standards to determine program eligibility. Consequently, how these new geographic standards are used has important implications for rural areas.

For example, the current Medicare hospital wage index is based on the previous MSA/non-MSA classification system. Hospitals located in or geographically reclassified as MSAs receive payments based on a wage index calculated yearly by CMS for their specific MSA. The wage index is based on how the hourly wages paid to hospital employees in an MSA compare to other MSAs. Hospitals located in non-MSAs received payments based on a single Statewide rural wage index.

In 2004, CMS will have to decide how the new OMB classification system will impact the wage index calculations. Micropolitan areas do not fit into either of the current wage index categories. CMS will need to decide if Micropolitan areas should be considered separate areas that would require a wage index similar to the Metropolitan areas, or if they should be included in the Statewide rural index. In addition to addressing the area wage index calculations under the new definitions, CMS will also have to address the geographic reclassification system and how the new categories will impact currently reclassified hospitals and those seeking reclassification.

There are likely other potential impacts across the Department where geographic location is a key determinant of eligibility for categorical programs.

The Committee urges the Department to analyze any potential changes thoroughly. In its initial *Federal Register* announcements regarding the new standards, the Committee believes OMB clearly indicated that Micropolitan areas should be viewed and treated as non-MSAs.

Obesity and Wellness

Obesity and the proportion of Americans who are overweight have reached epidemic proportions according to the Surgeon General.⁸ The proportion of U.S. adults who are obese increased from 14 percent to 22 percent between the late 1970s and early 1990s.⁹ Obesity has been associated with many chronic health problems including heart disease, diabetes, hypertension and some cancers. Nationally, obesity rates are higher among residents of rural areas. Regular physical activity reduces the risk for obesity. However, being inactive during leisure time is also more common among rural residents.¹⁰

Rural residents have long been plagued by higher rates of chronic disease and limitations on activities of daily living. Across the country, there is considerable evidence mounting about the link between current lifestyle and dietary habits and growing rates of obesity and related diseases.

This is an issue that the Secretary has spoken out on throughout his tenure. In response, the Department began the *Steps to a Healthier US* community grant program. Administered by the Centers for Disease Control and Prevention, this program provides \$13.7 million in grants to communities for diabetes, obesity and asthma prevention efforts that address three related risk factors: physical inactivity, poor nutrition and tobacco use. Of the total funds for this project, \$9 million was designated to fund large cities, \$250,000 was designated to fund one Tribal application, and \$4.4 million was designated to fund programs in small cities and rural communities.

The funding is to be targeted to at-risk populations including border populations, Hispanics and Latinos, Native Americans, African Americans, Asians, immigrants, low-income populations, the disabled, youth,

Addressing Obesity in Rural Communities

If Texas is a bellwether, rural America may be facing a dramatic challenge in addressing problems with obesity.

During its visit to Uvalde, Texas in June of 2003, the Committee heard testimony from Dr. Eduardo Sanchez, the Texas Health Commissioner. Dr. Sanchez discussed the issue of obesity and its impact on his state, much of which is rural. He noted that 60 percent of adults in Texas are overweight or obese and 40 percent of fourth graders are overweight or obese.

In some ways, Texas is a microcosm of the rest of the country. It has both large urban areas, as well as vast stretches of isolated territory dotted by small towns. It is also a State with a significantly mixed ethnic population.

Dr. Sanchez noted that the growing incidence of obesity poses an increasing burden on the health care system given its associated risk factors for diseases such as diabetes, cardiovascular disease and stroke. He noted that it is a State-wide problem but one that posed even more dramatic challenges in rural areas given the limited number of providers and a more limited infrastructure.

Dr. Sanchez told the Committee that he believes health care must be redefined to include both public health and medical care. More effort needs to be put into prevention, he said, or the health care system will be facing huge costs down the road.

“I’m quoted saying a lot that the physical health of Texas will affect its fiscal health, and I would say the physical health of rural America will affect its fiscal health,” Dr. Sanchez noted.

senior citizens, uninsured and underinsured people. Many rural residents fall into one or more of these identified demographics and many small communities suffer from the three targeted health risks at higher rates than the majority of the country. Clearly, the grants should allow smaller communities to address these is-

Crisis Spawns Innovative Model in WV Town

Necessity can be the mother of invention, particularly when it comes to creative health care partnerships.

In early 1996, with the Calhoun County Hospital on the brink of closing, the board of the Minnie Hamilton Health Center in Grantsville, West Virginia charged into the unknown by voting to become the first Federally Qualified Health Center to assume operation of a general acute-care hospital. Had the hospital closed, area residents would have been miles of mountainous terrain away from basic emergency services. In 1999 the hospital was converted to Critical Access status.

The Minnie Hamilton Health Center, which the Committee visited in September, demonstrates the power of community commitment to local health care. The Center has made capital improvements and expanded to offer day care, ambulance transport, mental and oral health services, school-based health clinics and physical therapy. It also operates a 24-bed long-term care facility that enables Calhoun County seniors to remain in their home community. Altogether, the Center employs 180

individuals, making it the second largest employer in Calhoun County and an important contributor to its economic base.

The Committee noted that the Center has also successfully integrated its health care and human services delivery. The Center works with the Calhoun County Committee on Aging (CCCOA). Health center outreach employees conduct a senior citizens wellness program that provides health information and fitness counseling to area seniors. The Center also used a portion of a Community-Based Initiatives grant to construct a walking trail for senior citizens. CCCOA reaches out to elderly residents of the Center's Long Term Care Unit and includes them in Committee activities such as shopping trips and travel opportunities. Minnie Hamilton Health Center CEO Barbara Lay views their close community outreach as nothing more than a typical aspect of the local culture in this rural West Virginia community. "People in Calhoun County have an innate ability to care for one another, and we see that here every day," Lay said.

sues, and the Department specifically assigned more than one third of the entire allocation for this purpose.

The Committee commends the Department for creating the grant program and for including language designed to ensure some rural participation. Still, the Committee is concerned about how effective the program will be in reaching out to small rural communities. The grant protocol requires that small cities and rural communities apply for funding through their State health department, which will then coordinate the grant management at the State level. According to the grant guidance, each State is authorized to choose "two to four communities of total resident size not to exceed 800,000 persons combined. Each community must be geographically contiguous and include a minimum population of 10,000." The current States with grant awards for the small cities and rural communities' component are Washington, New York, Arizona, and Colorado. Although the current approach used in the program to reach rural communities may have appeared to be a good

strategy to encourage coordinated efforts, the smallest rural communities, particularly remote communities in large States, will likely be excluded due to the geographical location and size requirements. The Committee is hopeful that future iterations of this program will address this concern.

Access to Specialized Health and Social Services

Every year, terminal diseases like Amyotrophic Lateral Sclerosis (also known as ALS or Lou Gehrig's Disease) affect the rural populations of America. While, proportionally, the numbers of those affected may be small, the need for specialized services is not bound by geographic boundaries. The glaring problem is the availability and access to diagnostic facilities, care facilities and services for the terminally ill. Across rural America, the Committee continues to hear reports of families who must travel hundreds of miles for diagnosis of these ter-

minal or life-threatening illnesses. Because the diagnosis process is very complicated, rural facilities often lack proficiency in identifying the illnesses. Once a diagnosis is accomplished, the family faces the lack of local services and must depend on specialized services located hundreds of miles from their residence.

There has been little research into this issue and the barriers faced by rural residents in accessing these specialty services. The Committee believes more attention is merited and hopes to analyze this issue in greater detail.

Health Care Cost Shifting and Rural Communities

There are changes taking place within the larger health care system that bear watching for their potential impact on rural communities. As health care costs continue to rise, third-party payers, both public and private, are making efforts to control or slow that growth.

There also has been a consistent increase in health insurance premium costs that has been felt across the country. Employers and the insurance companies they contract with are becoming extremely cost conscious about which providers they contract with. More of the premium increases also are being passed on to consumers. These changes have the potential for altering payment streams in a way that may put rural communities at a disadvantage.

The Committee is concerned about the impact of these market changes on the ability of rural providers to survive. Rural providers are extremely vulnerable to the projected rapid increase in defined contribution health plans that intend to make employees avoid providers with higher prices. There may be some remote rural or frontier areas where this may have no real impact, but for much of rural America, providers are vulnerable to competition with urban or suburban providers. If price (or quality concerns) are great enough, it may drive rural residents to travel greater distances for care and local caregivers may be bypassed. The Committee will monitor this situation.

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Integrating Behavioral Health And Primary Care Services In Rural Areas

Introduction

In recent years, health policy experts and health care providers have begun to encourage closer integration of behavioral health and primary care services, especially in rural areas of the U.S. The assumption underlying this push is that integration will increase access to primary and behavioral health care and, simultaneously, increase quality through enhanced coordination of services. In rural areas, where behavioral health workers and primary care givers are often in short supply, integration is vitally important. Integration of these services is one of the most effective strategies for maximizing the use of scarce rural health care resources and improving the quality of care for both behavioral health and primary care patients.

For the purposes of this discussion, references to mental health workers generally refer to psychiatrists, psychologists, social workers and advanced practice nurses. These are the professions used to designate mental health shortage areas in the country. This chapter also considers the roles of marriage and family counselors, individual counselors, substance abuse specialists and behavioral health workers.

Proponents of integration cite compelling arguments related to improving clinical care for behavioral health patients. The stark reality is that there are few behavioral mental health providers practicing in most small rural communities. Consequently, primary care physicians, advance practice nurses, physician assistants and other non-physician providers often are the first providers of care for patients with mental health problems. The shortages of behavioral health professionals can adversely influence the practice styles of primary care providers. For example, they may be reluctant to engage patients on issues such as depression when there are no mental health workers who can handle referrals.

Appropriately trained psychologists and other behavioral health professionals can provide consultation to physicians and nurses and contribute to the assessment

and treatment of mental disorders seen in the course of primary care. Patients with mental disorders make up an estimated 20-25 percent of all primary care patients.¹ Early detection and treatment of mental illness in primary care settings where behavioral health professionals are available can lead to better treatment and prevent more serious illness or even death. Integrated service delivery also facilitates the diagnosis and treatment of mental illnesses that are closely related to or result from physical disease. The increasing use of medications for mental illness also requires close monitoring and collaboration between behavioral health providers, who do not have the authority to prescribe psychotropic medications, and primary care providers who do. Further, integration provides opportunities for coordinated quality improvement initiatives and the adoption of evidence-based practices in behavioral health and primary care.

Integration also more effectively utilizes rural health manpower resources and, consequently, improves access to care. Access is improved when behavioral health and mental health workers are available at the same sites as primary care givers, or are easily accessible through appropriate referral arrangements. Integrated systems also help reduce transportation barriers for rural patients. Because it is unlikely that there will be a large growth of behavioral and mental health providers willing to practice in rural communities, appropriate integration of services could become a necessity.

Integration can reduce or eliminate the powerful social stigma often associated with mental illness in rural areas. Many rural patients are reluctant to be seen in settings where their privacy might be compromised, such as a private office or clinic specifically dedicated to mental health. In most small towns community members know the identity of each other's cars. Patients reluctant to have their car identified at a behavioral health location may not have the same reluctance to have community members see them in a primary care facility. The power of social stigma cannot be overstated. It causes

many individuals who need care to either ignore a mental health problem or attempt to address it as a physical issue. Stigma is less a deterrent to appropriate care when behavioral health professionals see patients in their regular primary care settings.

Access Issues In Rural Areas

The notion that rural Americans enjoy a healthier lifestyle and a lower incidence of mental disease is an unfortunate misconception. The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that one in five Americans suffers from a mental

disorder. Rural Americans, who make up more than one quarter of the U.S. population, experience incidence and prevalence rates of mental illness and substance abuse that are similar to or greater than urban residents.³ Rural areas also have a higher proportion of people who are at risk for poor mental health such as the elderly and the chronically ill.⁴

It is not possible to address linking mental and behavioral health with primary care in rural areas without first acknowledging the broader issues of access to rural mental health services. Mental health workforce shortages are among the most formidable health care challenges that rural communities face. In 2003, 74 percent of 1,196 federally designated Mental Health Professional Shortage Areas were located in rural counties. These areas house a large percentage of the country's rural population. This means that core behavioral health providers are not present in many rural and frontier communities. To further illustrate this point, the supply of psychiatrists is about 14.6 per 100,000 people in urban areas, compared to 3.9 per 100,000 in rural areas.⁵ Other mental health workers, like psychologists, social workers, marriage and family counselors and substance abuse specialists, are also in short supply.

Millions of rural Americans are without a regular source of mental health care, due, in part, to chronic rural behavioral and mental health provider shortages. Illustrating this point, a recent study in Maine showed that rural Medicaid beneficiaries are less likely than urban beneficiaries to have an outpatient mental health visit in a year's time.⁶ Further, in Maine and other States, the rate of rural Medicaid mental health visits has been linked directly to the lower supply of rural mental health providers. Many patients come to rely on primary care providers to meet their mental health needs. When the local primary care provider is not an option, the local hospital is the costly and inappropriate alternative. However, the hospital staff may not be fully trained or prepared to adequately diagnose and treat mental illnesses.

Provider shortages are the greatest single access barrier to rural behavioral health services, but there are other formidable issues. Lack of transportation is a major problem for many rural patients, particularly elderly populations that lack mobility. Poor or non-existing insurance coverage for behavioral health services is a significant deterrent for receiving care. Also, as noted pre-

New Freedom Commission Identifies Fragmentation

The President's New Freedom Commission on Mental Health issued its report² in July of 2003 and identified a system of care that is fragmented and inadequate.

The findings were part of a 16-month effort to evaluate and make recommendations to reform the current mental health delivery system. The Commission identified the following specific mental health disparities affecting rural and frontier communities:

- Inadequate access to care
- Provider shortages
- Greater social stigma associated with seeking mental health services
- Lack of a consistent plan to address rural mental health disparities as well as the need to establish models of care that address the unique needs of rural and frontier communities.
- Lack of a consistent definition of rural, which makes targeting funding for rural areas more difficult

For more information, visit:

<http://www.mentalhealthcommission.gov/>

Texas Site Visit Highlights Mental Health Shortages

Access to mental health services in rural communities has long been limited and the Committee saw dramatic evidence of this during a site visit to Uvalde, Texas in June of 2003.

Uvalde and its surrounding three counties (an area roughly the size of Connecticut) are served by one psychiatrist and two psychologists. There are also acute shortages of substance abuse counselors, social workers, marriage and family therapists and pastoral counselors. Uvalde is not unique. In rural Texas and elsewhere in the country, the availability of behavioral health workers is profoundly influenced by population density, with the least densely populated areas facing enormous challenges in recruiting these workers.

viously, the social stigma often associated with mental illness prevents many rural citizens from obtaining needed services. Although these and other access issues are generally beyond the scope of this report, they are partially addressed by strategies aimed at integrating behavioral health care with primary care services.

Rural Strategies For Integration

Most rural citizens have at least some access to primary care services, but this generalization applies less often to behavioral health services. Although it is difficult to generalize across the widely different rural areas of the country, it is probably safe to characterize the current environment for rural behavioral health services as one where:

- Primary care practitioners have the major responsibility for diagnosing and treating common mental illnesses such as depression;
- Behavioral health services are highly fragmented due to manpower shortages;
- There are separate facilities or locations for mental and physical health;

- Autonomous behavioral health and primary care providers practice with informal referral relationships; and
- Primary care and behavioral health providers do not share joint responsibility for managing the same patient.

Rural strategies to address these issues range from diagnosis and treatment by a fully integrated clinical team of primary care and behavioral health providers to the use of telehealth technologies for linking rural primary care providers with distant mental health professionals. Middle-ground strategies include the co-location of behavioral health and primary care services in physicians' offices, clinics, or hospitals, and the development of formal referral relationships among primary care providers and mental health professionals both within and outside the local community. Dual certification of providers in both primary care and mental health is another significant strategy for integrating services. The methods available to achieve integration will vary depending on the unique needs and resources of each community. Currently, there is no reliable data on the prevalence or efficacy of different models for integration.

Some States like Oregon, Montana and Arizona have developed telemedicine systems that link rural primary care providers with distant mental health specialists. Telecommunication technologies have been used for some 40 years to provide limited mental health interventions, mostly on an experimental basis. Beginning in the 1990s, however, the use of interactive telecommunication technologies flourished. The number of telemedicine programs in the United States grew from nine in 1993 to over 100 in 1997, with most providing mental health services. According to a study by the Office for the Advancement of Telehealth (OAT), the seven most active telemental health projects in the nation conducted approximately 70 percent of all the telemental health service contacts, as reported by the 50 most active projects in 1996.⁷

In eastern Oregon, rural primary care providers use telemedicine technologies to consult with mental health professionals at the nearest urban medical center. Some applications involve consultations between medical professionals; others make use of the technology for direct

provider-patient encounters. While health professionals disagree on the effectiveness of direct provider-patient encounters using telehealth technologies, telehealth continues to be an important option for providing training, consultation, and support to rural primary care providers in the face of continued shortages of behavioral health practitioners.

Co-location of rural primary care and mental health providers is a possibility for even the smallest rural communities, assuming the availability of providers. This could be accomplished simply by placing a psychologist or mental health nurse in a primary care physician's practice, a Rural Health Clinic (RHC) or rural Critical Access Hospital (CAH) outpatient department. In some cases, it may only be necessary for these providers to visit the rural clinic a few days a month or once a week. In other instances, when justified by volume, the behavioral health provider might be available on an equal basis with the primary care provider. The provision of mental health and consultation services at primary care sites can be more effective than referrals to mental health centers.

The Committee visited several communities in West Virginia where integrated services had been developed through creative collaborations and mergers of providers already located in the communities. In one community a newly started Community Health Center had placed limited license psychologists on-site through an arrangement with a nearby Community Mental Health Center. The psychologists work down the hall from primary care providers to help patients with behavioral health issues related to their physical health. They counsel patients on behavioral modifications related to diet, exercise and the use of medications, and discuss cultural resistance to care, family support and other issues with them. At another location the merger of a CAH and a Community Health Center had created a critical mass of providers that allowed the development of school-based behavioral health programs. Both sites faced difficult regulatory and payment issues, but the arrangements appeared to work to the benefit of patients and providers alike.

Behavioral health providers such as substance abuse counselors, mental health nurses, marriage counselors, etc. can be more effective and accessible if linked with primary care providers in these settings. They can also be shared among primary care providers in other rural

Collaborative Models Tested

Collaborative models between rural psychologists and family physicians have been formally tested in rural Texas and Wyoming. The models demonstrated that proximity, in terms of location and accessibility of the physician and psychologist, enhanced the ability of the team to collaborate in the treatment process. The availability of the psychologist also improved the likelihood of referral for patients with mental problems.⁸

The co-location of mental health and primary care services has recently become a significant new initiative involving Federally Qualified Health Centers (FQHCs) in rural areas. As part of the President's ongoing effort to expand the number of health centers, HHS officials are encouraging applicants to include mental health in their service delivery.

community settings. The Department of Health and Human Services can promote integration in rural areas by identifying models that work and making this information widely available.

Barriers To Integration Of Services

While integration is theoretically logical and there are significant numbers of successful models, the system, for the most part, remains fragmented. In large part, that is because there are significant barriers to the development of integrated primary care and mental health services in rural areas. Foremost among them is the higher percentage of rural citizens uninsured and under-insured for both physical and mental health. Lack of insurance profoundly affects the supply of health care providers and keeps many millions of rural Americans from obtaining needed care. However, this chapter does not specifically deal with broad insurance issues. Rather, it briefly describes some Federal and State policy issues that also affect the supply of mental health professionals in rural areas and impede efforts to integrate primary care and mental health services.

Payment Policies

Medicare payment and coverage policies have a significant influence upon where mental health and behavioral health practitioners choose to practice. The Medicare program is especially important to mental health payment policy because many States and private insurers choose to follow the Medicare rules for reimbursement. Medicare pays for outpatient, inpatient and partial hospitalization for treatment of mental illness. Coverage for mental health services is very similar to coverage for physical illnesses. However, the Part B coinsurance rate is much higher (50 percent coinsurance) for mental health services than for physical health services (20 percent coinsurance). For rural residents with low incomes, the high coinsurance rate makes paying for mental health services nearly impossible. Because consumers are more sensitive to prices for mental health services than for physical health,⁹ they are less likely to seek mental health services.

Currently, Medicare pays physicians, psychiatrists, psychologists, social workers and advanced practice nurses directly for mental health services. It does not reimburse marriage and family therapists or licensed professional counselors. Since commercial insurers and State Medicaid programs often follow Medicare's lead, the effect is to give many Masters' level practitioners little incentive to practice in rural areas. Further, practitioners who are unable to bill directly for their services must work under the auspices of a reimbursable provider, and in rural areas reimbursable providers often cannot be found.

Providers currently excluded by payment policies argue that direct payment for their services could actually reduce Medicare costs by reducing emergency room visits and encouraging more judicious use of mental health services. However, the Medicare Payment Advisory Commission (MedPAC), in its June 2002 report to Congress, stated that an increased volume of mental health services would offset the resulting savings. Others have disputed those findings, arguing that the data and modeling relied on by MedPAC was inconclusive with respect to added costs. There is no resolution of this issue, but rural mental health advocates believe that provider payment limitations must continue to be examined for their impact on the recruitment and retention of mental health professionals in rural areas.

Current Medicare payment policy also impedes access to behavioral health services in RHCs. There are approximately 3,500 federally certified RHCs in the country. They are much more numerous in rural areas than FQHCs or Community Mental Health Centers. In many small rural communities they may be the only source of primary care available. While these clinics are also authorized to provide mental health services in tandem with primary care, few have done so, in part because of reimbursement limitations. Under Medicare's cost-based payment system for RHCs, they are able to recover only about 50 percent of their costs for mental health services. RHCs are also limited in the types of

Sustainability of Integration Model Proves Difficult

Dr. David Hughes and his staff at the Cabin Creek Health Center primary care clinic in Cabin Creek, West Virginia have set up a model program for integrating behavioral health and primary care at their small clinic in the Southwest mountains of the state.

The clinic houses not only 10 physicians and four nurse practitioners but also two Masters-level mental health specialists. The health professionals work as a team to address the primary care and mental health needs of this small community. When patients visit the clinic, they first meet with a mental health provider who conducts a general screen to identify any unmet behavioral health needs. The patient's primary care needs are then addressed and follow-up appointments for either health or behavioral health are scheduled.

While the model has been successful, according to Dr. Hughes, lack of reimbursement may make it unsustainable. Clinic officials noted that Medicaid only reimburses services provided by select behavioral health providers. Medicare has similar policies. This burdens the program because approximately 50 percent of the patients receiving behavioral health interventions are uninsured and Medicare and Medicaid are the primary means of payment.

providers they can use to deliver mental health services. Further, RHCs are paid less than FQHCs for behavioral health services, even when the services are comparable. These factors act as powerful deterrents to integrated care in RHCs, places that have great potential to provide such services.

State Licensure and Scope of Practice Policies

Provider payments are linked to State licensure and scope of practice policies that determine which providers are paid and which services they are authorized to provide. A recent study by the Edmund S. Muskie School of Public Service in Maine describes the importance of State licensure laws and scope of practice acts to the delivery of behavioral health services in rural areas.¹⁰ The study examined licensure laws and administrative rules for social workers, psychologists, professional counselors and marriage and family therapists in the forty States where at least ten percent of the population is rural. Several of the study's findings relate directly to the issue of primary care and mental health services in-

tegration.

The study found that State licensing laws and scope of practice acts are often inconsistent with Medicare payment policies. For example, it found that the number of States permitting social workers to perform diagnosis and psychotherapy is not significantly different from the number of States permitting marriage and family therapists to perform these same services. Yet Medicare will reimburse social workers, but not marriage and family therapists for these services. This suggests that Medicare and other payers need to reconsider payment and coverage policies regarding some non-physician behavioral health providers. The Federal government also could play an important role in developing model scope of practice acts that would address rural issues.

The Maine study also discussed issues related to provider supervision requirements for limited license providers. Many States do not allow certain classifications of behavioral health providers to train and practice without supervision. Many require supervision to be performed by an advanced member of the same behavioral health profession in settings that allow face-to-face interaction between the practitioners. These policies are

Summary of State Statutes and Administrative Code With Respect to Diagnosis and Psychotherapy (N=40 States)				
	Permitted	Permitted as % of States that license	Prohibited	Not addressed in statute or code
Diagnosis				
Psychologist	37	92.5	0	3
Social Worker	30	75	0	10
Marriage and Family Therapist *	24	70.6	0	10
Licensed Professional Counselor **	23	62.2	0	14
Psychotherapy				
Psychologist	35	87.5	0	5
Social Worker	31	77.5	0	9
Marriage and Family Therapist	25	73.5	0	9
Licensed Professional Counselor	16	43.2	0	21
<p>* Total number of states that license MFTs is 34 of the 40 states surveyed.</p> <p>** Total number of states that license LPCs is 37 of the 40 states surveyed.</p> <p>Source: Maine Rural Health Research Center.¹⁰</p>				

relevant to psychologists, social workers, marriage and family therapists and other behavioral health workers in the States. Studies have shown that physicians and other health workers tend to practice close to where they receive their training. Thus, State laws on supervision can severely limit recruitment efforts in rural communities where advance practitioners are not available to perform the required supervision. A related issue concerning limited license practitioners is the perception that the quality of care is less when they are used, despite a lack of data that supports this perception. Outcome data and other performance measures are needed to address this misconception. This is especially important to rural areas where limited license providers can improve access to care (lack of access to care is itself a quality issue) and may be more easily recruited to rural practice sites.

The Maine study also addressed the controversial issue of prescriptive authority for non-physician mental health personnel. It highlighted the fact that in 2002 New Mexico became the first State to grant prescriptive authority to psychologists. The decision was based largely on the scarcity of more highly trained mental health personnel in rural areas of the State. The law requires psychologists to undergo extensive training to qualify for the prescription authority and also requires close monitoring in its execution. Many mental health experts believe that the lack of prescription authority for qualified psychologists is a deterrent to their willingness to practice in isolated rural areas and detracts from their ability to practice effectively in integrated primary care settings.

The study did find some exemplary practices in the States that lessened the adverse effects of licensure and scope of practice laws in rural areas. For example, New Hampshire allows candidates for licensure to be supervised by almost any mental health professional, opening more possibilities for qualified supervision in rural areas of the State. States such as Colorado, Kansas and Wyoming allow electronic supervision, acknowledging its necessity for rural practice sites.

Training

Patients with mental illness make up a significant proportion of primary care patients in both urban and rural areas. Yet most primary care providers are not well

trained in the diagnosis and treatment of mental disorders. Primary care physicians fail to detect psychiatric disorders one half to two thirds of the time.¹¹ The greater dependence on primary care physicians, together with chronic shortages of mental health professionals, increases the likelihood that many mental health patients in rural areas will not receive necessary care. The necessity of enhancing the mental health training of primary care physicians is widely recognized.

On the other hand, few mental and behavioral health professionals are educated and trained to work in primary care settings. For example, there are very few graduate programs, internships and fellowships available that focus on primary care psychology. Even fewer programs are available that provide education and training programs on-site in rural communities. Nevertheless, it is clear that patients benefit when primary care providers and mental health professionals work collaboratively in the diagnosis and treatment of mental illnesses.

Improving Access to Integrated Services

Federal programs supporting behavioral health services are somewhat fragmented and there are sizable holes in the rural mental health safety net. For many years government funded Community Mental Health Centers were the mental health safety net for millions of Americans. Until the mid-1980s these centers served all those in need regardless of ability to pay. When the program was converted to State block grants, the States shifted their focus to concentrate on patients with the most severe mental illnesses and on children. Most other patients were left unserved. Funding for the program has also declined and the clinics were never a universally available source of care for rural communities. Further, this program and other Federal initiatives did not focus specifically on the issue of linking mental health services with primary care.

A few smaller Federal programs are attempting to address the goal of primary care and behavioral health integration. The Health Resources and Service Administration (HRSA) has a Primary Care Integration initiative and is developing models for Federally Qualified Health Centers (FQHCs) that will enhance their ability

to integrate primary care with behavioral health. About 50 percent of FQHCs are serving rural areas, but their distribution is somewhat skewed toward areas east of the Mississippi River. Nonetheless, a major aim of the initiative is to provide coordinated primary care and behavioral health services at the clinics. One important limitation is that FQHCs may be precluded from having direct contractual arrangements with private sector providers given some of the board requirements under which health centers operate. Nonetheless, the number of FQHCs is projected to double over the next few years, and given their commitment to mental health and primary care integration, this expansion may bring substantial new benefits and resources to rural communities. The move to integrate primary care and behavioral health care in CHCs is also supported by HRSA's ongoing efforts with the Health Disparities Disease Collaborative initiative, which included depression as a key focus area.

The Office of Rural Health Policy in HRSA awards Rural Health Services Outreach Grants and Rural Network Development Grants to rural communities for demonstration projects that improve access to care and promote better systems of care. In FY 2003, 29 of 112 Outreach grantees organizations provided mental or behavioral health services. HRSA is also supporting successful applications of mental telehealth services that link rural primary care givers and their patients with mental health specialists at distant urban locations. OAT also funds telemedicine projects that may focus on behavioral health care needs. These and other programs supported by HRSA are highly competitive because of limited funding, and behavioral health/primary care integration is only one of many eligible activities.

Other Federally supported programs are important, but have a less direct effect on primary care/behavioral health services integration. For example, the National Health Service Corps in HRSA places mental health workers in underserved rural areas of the country, but mental health, and more specifically, rural mental health, is split among several areas of need. The Substance Abuse and Mental Health Services Administration, through its network of State offices and agencies, is promoting integrated models of care, but without a significant emphasis on rural areas. Funding for the program is also quite limited. New models of integrated services are emerging from Medicaid Mental Health Managed

Medicare Change May Offer Opportunities for Increased Integration

Recommendations from a September 2003 U.S. General Accounting Office (GAO) report¹² and a subsequent change in law may make it easier for small rural hospitals to also offer mental health services.

Thanks to the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), Critical Access Hospitals (CAHs) can now operate a psychiatric Distinct Part Unit (DPU) of up to 10 beds without it counting against their acute-care bed limit. Many rural advocates have supported such a provision for years, and they were buoyed by the recommendations from the GAO report that suggested increased flexibility in the law. This report helped persuade legislators to use MMA to amend the existing law.

The GAO report examined a number of barriers for conversion to CAH status. It found that many rural hospitals otherwise eligible for conversion were prevented from doing so because of the presence of an inpatient psychiatric or rehabilitation DPU. Even when conversion would benefit many hospitals financially, they were reluctant to give up what they saw as a valuable community service. Altogether, the GAO discovered 25 instances in which hospitals were forced to close a DPU in order to undergo CAH conversion. The report cited this as potential barrier to accessing psychiatric and rehabilitative care in rural areas, because, while 25 percent of Medicare beneficiaries are rural residents, only eight percent of rehabilitative and 17 percent of psychiatric beds were located in rural areas in FY 1999.

Some advocates are hopeful this provision will help ease an important barrier to providing psychiatric and rehab services to rural residents in their home communities.

Care programs in the States, but few of these are found in rural communities.

It should also be noted that some RHCs have been providing behavioral health services for as long as ten years. That success has been limited by payment policy issues, including lack of parity between RHCs and FQHCs for reimbursement for behavioral health services and limitations on the types of providers who can provide behavioral health services in RHCs.

HRSA's Bureau of Health Professions provides grants to health professional training schools that support the training of mental health and primary care professionals. The Quentin N. Burdick Rural Program for Interdisciplinary Training supports innovative training that prepares health care providers for practice in rural communities. The program emphasizes joint training opportunities for multiple health professions. In FY 2002, the program supported 28 projects for a total of \$6.5 million. HRSA also supports other programs within Title VII and VIII of the Public Health Service Act that can address primary care and behavioral health integration. This provides an opportunity for amending, expanding and enhancing these programs to support more integrated models of care.

There are other Federal programs across many different agencies that support increased access to behavioral health services. They are too numerous to mention in this report. However, Federal programs and policies alone will not be able to meet the overwhelming needs of rural communities for increased access to behavioral health services. The most difficult issues of behavioral health/primary care integration in rural areas – those related to State licensure laws, scope of practice limitations for behavioral health workers, training of behavioral health and primary care workers, contentious professional prerogatives among various groups of behavioral health and primary care providers, and other problems – must be addressed by States, health professional schools and the health professions. Nevertheless, Federal programs can help by continuing to provide valuable resources and improving the policy environment for developing integrated mental health and primary care services.

Conclusion

The Committee selected the topic of primary care and behavioral health integration because it believes that much greater emphasis must be placed on policy makers developing seamless systems of care that recognize relationships between mental disorders and physical health. The Committee also believes that in rural areas integrated systems will improve access to care and enhance quality. During preparation of its report, the Committee visited rural sites where integrated systems are in various stages of development. The sites are facing an array of issues related to insurance coverage, Medicare regulatory and administrative requirements, Medicaid payments, limited scope of practice for non-physician providers and recruitment of workers in behavioral health. The systems are fragile and heavily dependent on grant support for their continued operation. Yet each site has been able to cobble together some integrated programs with demonstrable benefits to patients and providers alike. The Committee concluded from its visits that policy makers, regulators and payers must become more flexible in order to create an environment where integrated systems can flourish.

This goal will be more difficult to achieve in rural and frontier communities for the reasons briefly discussed in this chapter. Moreover, these communities are often preoccupied with the need to acquire and sustain a basic level of primary care services. They may view behavioral health as a lesser priority and be poorly informed about the possibilities and benefits of integrating the services that are currently available. Overburdened rural providers in both behavioral and physical health may not be able to provide the leadership required to accomplish this change. Again, the challenge for policy makers is to continually examine the needs of rural communities and help them develop strategies for creating integrated systems that can be sustained.

The Department of Health and Human Services has the largest Federal role in supporting mental health and behavioral health services and improving access to care in rural areas. Behavioral health and primary care are among its highest priorities. The Committee's recommendations that follow focus on areas in which the Department can influence the integration of behavioral health and primary care services in rural areas.

Recommendations

- The Secretary should work with the Congress to amend Section 1861(s)(2) of the Social Security Act to authorize State-licensed marriage and family therapists, licensed professional counselors and other behavioral health providers to provide behavioral health services as qualified mental health care service providers. The Secretary should also work with Congress to authorize Medicare payments for those services by amending Section 1833(a)(1) of the Social Security Act, as needed, to ensure that payment.
- The Secretary should seek to broaden the definition of originating sites for telehealth services to include private physician offices under Title XVIII of the Social Security Act and ensure that all Medicare-eligible providers can offer mental health services via telehealth consultation.
- The Secretary, under the auspices of Title XVIII and Title IX of the Social Security Act, should work to identify States with model licensure laws and scope of practice acts for non-physician behavioral health providers. The Secretary should share them with other States and policymakers in order to facilitate similar practices in rural areas of the country. The Secretary should also work with States and behavioral health professional associations to increase flexibility in State requirements for supervision of limited license behavioral health providers that would allow more rural training, either in person or through supervision delivered via telehealth technologies.
- The Secretary should support increased funding for the Quentin N. Burdick Program for Rural Interdisciplinary Training. The program is authorized under Title VII, Section 754 of the Public Health Service Act. Grants awarded through the program can support innovative models and demonstrations of interdisciplinary care in rural areas. The program is uniquely suited to the support of programs that foster the development of integrated primary care and behavioral health care delivery systems.
- The Secretary should support increased funding for the Graduate Psychology Education Program authorized under Title VII, Section 755(b)(1)(J), of the Public Health Service Act. This program supports grants to schools accredited by the American Psychological Association to help them plan and operate programs that foster an integrated approach to health care service and that train psychologists to work in underserved areas. The program was not included in the President's budget for 2005.
- The Secretary should provide increased support for scholarships and loan repayment for behavioral health care providers under Section 331 of the Public Health Service Act.
- The Secretary should work with the Congress to amend Title XVIII and Title XIX of the Social Security Act to require parity in payments and the resulting co-payments for mental health care services under Medicare and Medicaid.
- The Secretary should work with the Centers for Medicare and Medicaid Services in administration of Section 1834(g) of the Social Security Act to clarify that Critical Access Hospitals can and should have the flexibility to provide mental health services as dictated by community need within the normal protections for patients.

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Access to Oral Health Care In Rural Areas

There is a growing understanding of the critical role oral health plays in overall well-being. However, oral health has been described as one of the single greatest unmet health care needs in the United States¹. The many factors contributing to this problem exist regardless of geographic classification, but they are often more pronounced in rural areas. A significantly lower proportion of dental health professionals, combined with increased poverty, lower insurance rates, geographic isolation, lack of water fluoridation and numerous other issues, make rural oral health problems particularly acute.

Poor oral health is a problem throughout the health care system and, for too long, dental care has been viewed as less important or separate from other aspects of health. However, the Department of Health and Human Services (HHS) *Healthy People 2010* report notes that “Oral health is an essential and integral component of health throughout life.”² Despite this knowledge, American performance on critical measures of oral health status remains alarming. The statistics speak for themselves. Dental caries (tooth decay) is the most common form of childhood illness, affecting more than five times as many children as asthma³. Similarly, 50 percent of adult Americans suffer from some form of gingival disease, and nearly 35 percent have periodontitis.⁴ Thirty percent of U.S. adults over age 65 have lost all of their teeth.⁵

While 44 million Americans lack health insurance, 108 million have no form of dental coverage.⁶ Contributing to the problem is a growing national shortage of oral health providers. As of September 2003, there were 2,235 Dental Health Professional Shortage Areas (DHPSAs), 74 percent of which were located in non-metropolitan areas.⁷ The acute shortage of dentists is expected to worsen in the coming years. In 1983 there were 5,756 dental school graduates compared to only 4,000 in 1990. This problem is compounded by the large number of dentists slated to retire in the next several years.⁸ To further exacerbate the problem, since 1986 seven dental schools have closed, and only two new ones have opened to replace them.⁹

The Effects of Unmet Care

Studies consistently show that poor oral health affects much more than a person’s smile. It results in lost school hours, lower productivity and costly emergency room visits, and it has been linked to broader and more serious systemic illnesses. In 2002, the Wisconsin Hospital Association reported that more than \$6 million in emergency room care was given to 22,000 patients with oral health problems.¹⁰ For many individuals, a visit to a hospital emergency room is often the first time they receive any form of dental treatment. Because most oral diseases are progressive, aggressive early childhood intervention could easily prevent many of these cases. However, for many children it is already too late; when they receive dental care they present with significant dental disease. The Surgeon General reports that 51 million school hours are lost due to oral health problems alone.¹¹ Bad teeth clearly can lead to social stigmatization and marginalization, and anecdotal evidence indicates that they can sometimes lead to diminished employment opportunities. For those who do work, poor oral health results in lost productivity. Nationally, 164 million work hours are lost a year because of the pain and discomfort associated with poor dental health.¹² It is becoming increasingly clear that unmet dental needs are accompanied by a high personal and social cost.

Also apparent is the artificiality of the traditional separation of oral health from overall physical health. Recent findings indicate a clear connection between certain oral diseases and broader systemic illnesses. Of these, the link between oral infections and serious heart conditions is the most supported by experimental evidence.^{13,14} A significant association between dental infection and atherosclerosis and coronary heart disease is indicated in multiple studies and periodontitis has been strongly linked with coronary heart disease.¹⁵ Poor oral health status also has been implicated as a cause of chronic obstructive pulmonary disease, and periodontitis in pregnant women is being investigated as a risk factor for premature births and low infant birth weight. Additionally, dental visits function as the primary tool

for detecting and initiating early treatment for oral and pharyngeal cancers, which are responsible for almost 8,000 deaths annually.¹⁶

Factors Limiting Access to Care

In order to understand the rural context of dental care it is important to be aware of the various factors limiting access to care throughout the United States. These factors are complex and vary within and between States. However, there are several fundamental problems that affect the provision of dental care nationally. These include low public financing, lack of dentists participating in Medicaid and the State Children's Health Insurance Program (SCHIP), uneven distribution of practitioners, poor coordination between dental and medical care, lack of private dental insurance and cultural attitudes toward dental care.

As discussed previously, only a small proportion of dental services are funded through Medicaid and SCHIP. All States provide some dental care to low-income children, and some reimburse care for poor adults. However, many dentists will not see Medicaid or SCHIP patients. A 1998 survey of State Medicaid providers revealed that only 16 percent of dentists were active participants in the Medicaid program.¹⁷

A 2003 study by the Child Health Insurance Research Initiative indicated that low-income children in areas with few Medicaid dental providers had a much higher rate of unmet dental needs.¹⁸ The Medicaid reimbursement levels typically offered by States certainly contribute to the low dental participation in the program. In 2000, only 13 States had reimbursement rates greater than two thirds of the usual customary rate (UCR) charged by dentists.¹⁹ In addition, Medicaid recipients often are perceived by dentists as being more likely to miss scheduled appointments and less likely to comply with dental advice.^{20, 21} Dentists also frequently cite the administrative burden associated with treating Medicaid patients as a reason for not participating in the program.²² In the late 1990s era of budget surpluses some States increased their reimbursement levels to approach the UCR. When this happened in Georgia the provider base increased by 63 percent and Michigan reimbursed 88 percent more dental visits. Still, in 1998 dental care accounted for only 2.3 percent of all Medicaid expendi-

Private Practice Dentist Plays Safety-Net Role

Dr. Bruce Cassis, a private practice dentist in Fayetteville, West Virginia, is the oral health care safety net in his small town.

Dr. Cassis, who played host to the Committee during a site visit in September 2003, sees all patients in his small clinic, regardless of their ability to pay or their insurance status. In doing so, Dr. Cassis' clinic serves as a reminder that private dentists can also be a key part of providing services to the underserved. The clinic serves a town of approximately 3,000 residents and works to develop individualized payment plans for patients who are unable to immediately pay out of pocket or who lack private insurance. Dr. Cassis commits at least 10 percent of his practice to Medicaid and other low-income patients.

"Everybody who works here lives here, and a lot of times it's our neighbors getting help," said Dr. Cassis. "We're just local people helping local people."

tures.²³ It is estimated that \$21.35 per child per month is necessary to provide adequate dental care to children, but in 1995 Medicaid paid only \$4.44 per month per child on dental services.²⁴

Access to care is further limited by a national maldistribution of dentists. Whether the total dentist population is adequate to meet U.S. needs remains uncertain. However, there is a broad consensus that the distribution of dentists is uneven, often compromising access to care in rural and central urban areas.²⁵ The dentist supply clearly affects patients' ability to obtain care. One study found that Medicaid-enrolled children are 24 percent more likely to obtain restorative dental care if they live in the county with the largest number of dentists in the State, rather than the one containing the fewest dentists.²⁶ One reason dentists cite for their reluctance to treat Medicaid patients is that doing so takes time away from patients who are able to pay higher out-of-pocket or private insurance rates. In areas with few dentists it is much easier and more lucrative for them to place such limits.

Linking Primary Care with Oral Health

At Community Health Development, Inc., a Federally Qualified Health Center in Uvalde, Texas, patients are assessed for oral health care needs at the same time they are seen for primary care.

The community health center in this Southwestern Texas town has long employed an integrated care model. Comprehensive, integrated and multidisciplinary primary care is provided to each patient. For example, when children report for a dental exam the staff screens immunization records. If something is not up-to-date, the child will be referred for immunization during the same visit. In the case of diabetes and other chronic conditions affecting oral health, providers work collaboratively to ensure that all needs are met. Pre-natal patients are engaged in an aggressive oral health education and treatment program. Periodic oral health monitoring is timed with pre-natal physician visits, and extensive education is provided about the expected infant's oral health and development.

Furthermore, while this assertion remains controversial, some sources cite restrictive practice laws for mid-level dental professionals as a factor limiting access to oral health care for many low-income citizens.^{27, 28} A 2003 Centers for Disease Control and Prevention (CDC) funded study conducted by the George Washington University Center for Health Services Research and Policy analyzed States' scope of practice laws and their effect on access to dental services. The study concluded that laws limiting dental hygienists' ability to practice without direct dental supervision, "operate as a barrier to the provision of preventive oral health services to low-income children by limiting the number of individuals who can provide such services."²⁹ Two separate studies demonstrated that hygienists are able to provide basic preventive oral care such as fluoride varnishes and dental sealants with a level of safety comparable to licensed dentists.^{30,31} However, concerns about the safety of allowing hygienists to independently administer preventive care is sometimes cited as a reason for restricting

their scope of practice.^{32,33}

Several States have recently initiated alternative practice models that allow hygienists increased autonomy to provide basic dental services; Colorado, for example, has allowed independent hygienists to practice for a number of years. However, for a variety of reasons, including lack of Medicaid reimbursement, most of these models have not significantly increased access to care.³⁴ Alaska is pursuing a different strategy and has begun training a new class of dental health aides that will provide care in the most remote Alaska Native villages.³⁵ Iowa, Washington and North Carolina have all developed models that train primary care physicians to administer preventive oral health care and dental referrals to young children in a primary care setting. In rural areas that face acute and growing dentist shortages, some form of alternative provider model may be particularly useful as a means to extend basic dental care to low-income residents. The Committee encourages continued research and demonstrations to evaluate the viability and efficacy of models that better integrate primary care medicine and dentistry, as well as efforts to provide school and community-based preventive dental services.

The Status of Oral Health in Rural America

For the most part, the problems facing rural oral health reflect those of the entire Nation. Along with the rest of the country, rural residents struggle with low dental insurance coverage or reimbursement, a lack of public financing for dental care, a shortage of dental providers willing to see Medicaid patients and cultural attitudes that place less value on receiving dental care than other forms of medical care. As the statistics will indicate the problem is, however, much more acute in rural areas. Many rural residents, particularly those in the most remote locations, face additional difficulties accessing oral health services. These include:

- Geographic isolation
- Lack of adequate transportation
- Lack of fluoridated community water supplies
- Increased poverty and age
- Lower dental insurance rates

- Acute provider shortages
- Increased difficulty finding providers willing to treat Medicaid patients

A variety of sources indicate that rural Americans have a poorer oral health status than the overall U.S. population. In particular, a series of studies published in 2003 indicate shocking oral health disparities in rural areas that cut across all age groups (see text box).^{36, 37, 38}

Overall in 2001, 67.1 percent of urban residents had visited a dentist in the previous year, while only 58.3 percent of rural Americans had done so.³⁹ One likely contributing factor is the significantly smaller percentage of rural residents with private employer-sponsored dental plans. Rural residents are more likely to be self-employed or work in small firms for whom the provision of dental coverage is much more difficult.⁴⁰ In large and small metropolitan areas the private dental insurance rate is 55.4 percent and 53.5 percent respectively, while only 39.8 percent of the rural population has a private dental plan.⁴¹ An additional factor contributing to this disparity is the severe shortage of dentists practicing in rural areas. The U.S. average for dentists is 52.5 dentists per 100,000 residents. In rural counties there are only 34.5 dentists per 100,000 people.⁴² As dental school graduates accumulate ever-increasing debt loads, fewer dentists are willing to locate in underserved areas where they typically earn less income. Studies consistently report that students who train in underserved areas are much more likely to practice in one, but many schools still do not rotate their students through clinics that provide care to underserved populations. Similarly, minority students are significantly more likely to work with other minority populations. The shortage of dental professionals providing care to rural Native Americans is particularly acute. However, in 2000 there were only 112 Native Americans enrolled in U.S. dental schools; that is one Native American student for every 35,000 Native Americans.⁴³

Rural areas are certainly not homogenous, and in more remote locations the average oral health status is even worse. This is particularly true for low-income residents of remote rural regions. In 2000, the GAO reported that only 22 percent of individuals in rural counties not adjacent to metropolitan areas and with incomes below 200 percent of the poverty level had seen a dentist in the previous year, compared to 29 percent in other ar-

Rural Oral Health Facts

- 41 percent of rural children lack dental insurance compared to 34.7 percent in urban areas.³⁶
- 69.9 percent of rural children and 73.6 percent of urban children visit a dentist during the course of a year.³⁷
- 51.4 percent of rural children and 61.7 percent of urban children use dental services regularly.³⁸
- 58.3 percent of rural adults ages 18-64 and 65.8 percent of their urban counterparts saw a dentist in the previous year.³⁶
- 46.5 percent of rural adults ages 18-64 and 55.6 percent of their urban counterparts use dental services regularly.³⁷
- 31.7 percent of rural adults and 25.2 percent of urban adults have untreated dental caries.³⁷
- Nearly twice as many rural adults ages 45-64 have lost all of their teeth (16.3 percent vs. 8.8 percent).³⁷
- 58 percent of the rural elderly (age 65+) had not seen a dentist in the previous year compared to 47 percent of the urban elderly.³⁸
- 38 percent of rural elderly and 27 percent of urban elderly had not seen a dentist in the previous three years.³⁸
- 72 percent of rural and 66 percent of urban elderly lack dental insurance.³⁸
- 37 percent of rural and 27 percent of urban elderly are edentulous (have no remaining teeth).³⁸

eas.⁴⁴ The presence of a reasonably large town also appears to significantly impact provider availability. In non-metropolitan counties lacking a city with more than 10,000 people there is an average of only 29.0 dentists per 100,000 residents. Rural counties containing cities with larger towns have 41.3 dentists per 100,000.⁴⁵ Data is not available on specific oral health outcomes for remote rural residents, but one would expect them to be much lower than elsewhere in the country.

The Policy Response

At best, the Federal policy levers available to influence rural oral health care are limited in both scope and funding. Many of the issues discussed above fall under State jurisdiction. For example, scope of practice and licensure laws are controlled at the State level, as well as Medicaid and SCHIP reimbursement rates. However, there are a substantial number of Federal programs and initiatives that directly address rural oral health care needs. These include:

- Indian Health Service
- Federally Qualified Health Centers (FQHCs)
- CDC public health funding
- Bureau of Health Professions (BHP) workforce development programs
- Maternal and Child Health Bureau (MCHB)
- Federal Office of Rural Health Policy (ORHP)
- Medicaid and SCHIP funding
- Federally supported oral health research
- Surgeon General and CDC reports

The Indian Health Service

The Indian Health Service (IHS) is charged with providing health services to the nation's American Indian and Alaska Native populations, which tend to be concentrated in rural areas. It offers loan repayments for dentists and hygienists who agree to serve in an IHS facility. Despite its broad mandate to provide care to Native American populations, the utilization of IHS dental services is low. The user rate among Native Americans is only 28 percent in contrast to the national average of approximately 60 percent.⁴⁶ Furthermore, the IHS reports that dental disease rates are two to 10 times higher among Native American populations.⁴⁷ As elsewhere in the United States, part of the low user rate may be attributed to poor understanding of the importance of oral health. However, an inadequate infrastructure and lack of funding is certainly an important factor. Currently, 100 IHS dental positions, approximately 25 percent of the total, are unfilled. Recruiting providers

to serve Native American populations is challenging, particularly when it is relatively easy for dentists to earn more income in the private sector. Consequently, the provider shortage is projected to continue well into the future.⁴⁸

Federally Qualified Health Centers: The Rural Dental Safety Net

In many locations, particularly in rural America, the nation lacks a significant dental safety net. Federally Qualified Health Centers (FQHCs) are often the only health care access points for the nation's poor and uninsured. Currently, new start FQHCs are required to provide access to oral care as a provision for Federal funding, and the number of health centers providing dental services is increasing. In 1998, only slightly greater than half of all health centers had active dental programs.⁴⁹ The most recent Bureau of Primary Health Care data from 2002 indicates that 71.9 percent of 843 health center grantees provide preventive dental services, and 63.6 percent offer restorative care. Other health centers have agreements to refer clients off-site to receive dental services.⁵⁰

The FY 2004 budget includes significant funding to create new start health centers and the overall goal of the health center initiative is to place 1,200 new or expanded health centers in needy communities throughout the United States while reaching an additional 6.1 million Americans.⁵¹ Since half of the new centers are to be placed in rural areas, the initiative will undoubtedly increase access to care in many rural communities. However, new health centers will have to contend with rural provider shortages and, particularly in frontier and remote rural locales, geographic and transportation barriers unique to rural areas. Thus, while the health center expansion is a valuable and important tool to improve the provision of rural safety net dental care, it should not be viewed as the only solution for rural America. Innovative solutions for training and placing qualified providers in rural areas must be sought out and existing providers should be encouraged to offer care to low-income rural residents.

In addition to FQHCs, Rural Health Clinics (RHCs) are important components of the rural health care safety net. The Rural Health Clinic program was established by Congress in 1977. As of September 1999 there were

3,477 RHCs in 45 States.⁵² Like FQHCs, RHCs receive cost-based Medicare and Medicaid reimbursement for core medical services and are eligible to provide dental services, although they are not reimbursed at cost for doing so. The Committee believes that the Administration and Congress should look at expanding the RHC scope of services to add oral health services in that benefit package. RHCs are also subject to a cap on their payments that is lower than what FQHCs are paid for identical services. Unlike FQHCs, RHCs do not receive Federal grant support and often are solo or private practices. While RHCs are much more numerous than

FQHCs in rural areas, at this time very few offer dental services. The Committee believes that it is possible for RHCs to play a more important role in the rural dental safety net and encourages further exploration of this issue.

CDC: Dental Public Health Infrastructure

In many locations the dental public health infrastructure remains grossly inadequate. Almost all dental public health and health promotion activities are conducted by State and local agencies. *Healthy People 2010* objective 21-17 calls for all States to have a full-time dental director with a public health background. However, a 1999 survey conducted by the Association of State and Territorial Dental Directors (ASTDD) revealed that only 31 States had full-time dental directors.⁵³ The Centers for Disease Control and Prevention (CDC) is the largest Federal sponsor of dental public health activities and has initiated a number of programs to improve the infrastructure. In 2003, \$3 million dollars were awarded as cooperative agreements between the CDC and 12 States and one U.S. territory to strengthen their oral health programs.⁵⁴ The CDC is also encouraging States to develop a comprehensive dental plan and has collaborated with ASTDD to produce and post online data from the National Oral Health Surveillance System (NOHSS). The NOHSS is designed to be a resource for public health programs and provides detailed information about oral health status and community water fluoridation at a State and national level.⁵⁵

The fluoridation of public water has proven to be one of the simplest and most effective caries-reducing public health interventions. While every dollar spent on water fluoridation has been shown to save \$38 in treatment costs,⁵⁶ only 57.6 percent of the U.S. population currently has access to a fluoridated water supply.⁵⁷

Unfortunately, specific data about the proportion of rural and urban residents with access to fluoridated water systems is unavailable. However, it can be reasonably assumed that fewer rural residents have access to such systems. For example, cost represents a much more significant burden to smaller water systems. In towns with fewer than 5,000 residents it is three times more costly to fluoridate community water than towns with

Mounting Challenges for Rural Dentists

The experiences of dentist Dr. Dan Brody in the small West Virginia town of Cedar Grove are a perfect example of the challenges providers often face in community health settings.

The former dental director of Fort Gay Health Center, Dr. Brody came to the Cedar Grove Clinic temporarily in September 2003 after its dental director left to join a new start clinic elsewhere. He was stunned by the magnitude of the need the community health center was charged with meeting. Many people traveled for hours to receive care on a sliding fee payment schedule. When they came, many patients' diseases had progressed beyond hope of repair and much of his time was spent pulling teeth that simply could not be saved. The center's equipment was decades old and spare parts had to be "cannibalized" from other health centers. As with many other health centers, the dental facilities were "retrofitted" in less than efficient settings — in his case, in a former school principal's office.

Dr. Brody told the Committee about the difficulty of obtaining funds for health center capital improvements. The Health Center expansion provides funds for the construction of new start clinics, but not for capital improvements of existing facilities. However, he remains committed to meeting the needs of West Virginia's medically underserved population.

10,000-20,000 inhabitants, and six times more expensive than communities with greater than 20,000 residents.⁵⁸ In addition, small communities often lack the technical expertise and assistance necessary to maintain a fluoridated water supply. Of the approximately 60,000 U.S. water systems, only around 14,000 are fluoridated. The vast majority of U.S. water systems are relatively small, with large systems that serve more than 100,000 people representing only 0.6 percent of the total, but serving 45 percent of U.S. residents.⁵⁹ These large systems are much more likely to be fluoridated than the smaller ones that typically serve rural Americans. Additionally, 12.6 percent of the U.S. population obtains water from the generally unfluoridated private wells that tend to be located in rural areas.⁶⁰

Other effective methods for reducing dental caries include varnishes, dental sealants and fluoride washes. Data indicate that minority and low-income children have a much lower utilization of dental sealants and fluoride treatments. Only three percent of low-income children have had sealants applied, while the national average is 23 percent.⁶¹ As with fluoridation, data on rural and urban differentials in sealant use are currently unavailable. In order to identify any disparities, the Committee encourages additional investigation of this topic.

Much of the Federal support for community water fluoridation and school-based sealants and fluoride wash programs is provided through the CDC's Preventive Health and Health Services (PHHS) Block Grant. This grant, established by the 1981 Omnibus Budget Reconciliation Act, pooled the community water fluoridation grant with several other categorical public health grants to create a single program. Of the over \$178 million funded by the PHHS Block Grant in 2002, nearly \$3 million was used by States for oral health and community water fluoridation.⁶² The Committee strongly supports all efforts to fluoridate rural community water supplies and to increase the utilization of other caries-prevention treatments among rural residents. The Committee believes that additional research should be conducted to identify the existence and causes of any urban/rural disparities in the provision of preventive dental care.

HRSA Programs

Bureau of Health Professions: Workforce Development and Dental Education

HRSA's Bureau of Health Professions' (BHPr) Title VII programs provide a valuable but admittedly limited tool for increasing the rural dental workforce. HRSA data indicate that Title VII programs result in a higher proportion of primary care health professionals willing to practice in medically underserved areas.⁶³ Example programs include funding for general and pediatric dentistry residencies, loan repayment programs for oral health professionals willing to practice in Health Professional Shortage Areas, and Area Health Education Centers that emphasize education and training in a primary care setting.

The Quentin Burdick Rural Program for Interdisciplinary Training is a particularly valuable component of the rural workforce development strategy. The program specifically addresses the need for health providers able to work together to meet the complex demands of rural practice. Of the 15 new Quentin Burdick grantees awarded in 2002, six provided rural interdisciplinary training to dentists or dental hygienists.⁶⁴ The Committee feels strongly that dental care should be an important aspect of any interdisciplinary approach to rural health care, and attempts to involve dental professionals in such programs should be strengthened.

The Health Careers Opportunity Program (HCOP) also provides some valuable training opportunities. HCOP funds a wide variety of programs including the recruitment of disadvantaged students into the health professions and community-based clinical experiences for dental students.⁶⁵ In the 2001 fiscal year 437 dental students participated in HCOP programs at six different dental schools.⁶⁶ The Centers of Excellence (COE) program fulfills a similar function, and provides some dental schools with funding to recruit minority students and expose others to practice opportunities in underserved, minority communities. Additionally, Area Health Education Centers (AHECs) are charged with ensuring an adequate supply of health professionals in underserved communities. AHECs encourage remote rural high school students to pursue a health professional career

Oral Health A Key Part of Innovative State Workforce Program

When West Virginia official began designing a statewide health workforce program to address the State's chronic health workforce shortages, the particular need for oral health providers quickly became apparent.

The workforce program which emerged, West Virginia Rural Health Education Partnership (RHEP), requires health sciences students in West Virginia (medical, dental, nursing, and pharmacy) to conduct a six-week rural rotation. The oral health portions of the program have helped increase access to dental services. Many dental students are able to provide services for almost no charge, thus providing valuable care while improving their clinical knowledge.

The program has met with outstanding success as a recruiting tool for rural dentists. Five of the six students who rotated with Dr. Bruce Cassis (see textbox on page 23) have located in rural areas, and four of the five students Dr. Dan Brody (see textbox on page 27) has hired for several FQHCs conducted their RHEP rotations with him. Most importantly, students are given a feel for the opportunities and leadership activities that are unique to rural practice.

"Students get a chance to see how they can become involved in rural communities," said Dr. Cassis. "The big picture message is they don't have to be in a big city to have the lifestyles they want."

through science education, mentoring programs, and career education and also sponsor training opportunities for health professional students in rural health clinics and other underserved practices.⁶⁷

The National Health Service Corps (NHSC) is one of the best-known workforce development programs. Authorized by Title III, Section 331 of the U.S. Public Health Service Act, it provides scholarships and loan repayment to dentists and dental hygienists willing to practice in the most underserved Dental Health Professional Shortage Areas (DHPSAs). As of October 2003,

293 NHSC dentists and 18 hygienists were working in underserved areas. However, 700 additional communities had requested one or more oral health clinicians and the need for more NHSC practitioners remains extremely high.⁶⁸

All of the programs mentioned above are important tools for combating rural dental workforce shortages. These shortages are a real and growing problem and it is important that all efforts are taken to increase the rural practitioner pipeline. The Committee strongly endorses programs that expose future dental practitioners to rural and underserved populations, as well as efforts to recruit rural residents into the dental professions. However, the Committee also notes that amount of funds dedicated to such programs is limited. For example, HCOP and Burdick received a combined \$43.1 million in FY 2003. The NHSC received \$171 million in FY 2003 but only a portion of that goes toward placing dental health practitioners. Likewise, all of the other Title VII programs shared \$92.1 million with oral health activities getting only a small portion of that total. While these are substantial dollar figures, it is important to note that they are spread out across the entire country's needs and are rather insignificant when compared to other forces such as Medicaid reimbursement or scope of practice that affect the pipeline of oral health practitioners.

MCHB and Title V Funding

The Maternal and Child Health block grant provides another resource to support oral health activities. This program gives grants to each State with funds to build infrastructure and provide population-based health services to millions of Americans. In 2000, 29 States included oral health as a priority area for the utilization of Title V funds. These funds are often used to provide school services. Title V and other HRSA programs support nearly 150 school dental programs that reach approximately 1,000 classrooms.⁶⁹ In FY 2003 the Bureau awarded approximately \$3 million in State Oral Health Collaborative Systems grants to 45 States and two U.S. territories.⁷⁰ These grants place a priority on increasing access to care for Medicaid and SCHIP eligible children. MCHB's Special Programs of Regional and National Significance grants also include the provision of oral health care and community water fluoridation as part of their mission. Community Integrated Ser-

vice Systems grants encompass projects designed to improve rural service systems, which could include initiatives that address oral health care needs.⁷¹ Unfortunately, MCHB does not have data indicating the amount of Title V funding that supports dental care in rural communities.

ORHP: Rural Health Care Services Outreach Grants

Rural Health Care Services Outreach Grants, administered by the Office of Rural Health Policy, fund several projects focusing on improving rural dental care. During FY 2003 five grants with an exclusive dental focus were awarded nearly \$1 million in funding. Seven other programs with a dental component were given over \$1.2 million.⁷² The Outreach grant program provides flexible funding for a wide variety of rural health programs and is an extremely important funding source for many rural health initiatives.

CMS: Medicaid and SCHIP Funding

Medicaid dental coverage for children has been mandated since 1967 as part of the Early and Periodic Screening, Prevention, Diagnosis and Treatment (EPSDT) benefit. The measure was created as a way to guarantee that children receive adequate preventive medical care that will ensure proper development and foster a lifetime of good health and achievement. The EPSDT requirement was refined by the 1989 Omnibus Budget Reconciliation Act, which required States to establish participation goals and report the number of children that receive dental care to the HHS Secretary.⁷³ In this way, the Department of Health and Human Services attempts to leverage States to provide reimbursement levels that are sufficient to ensure adequate access to care as mandated by the EPSDT requirement. While the provision of dental care to low-income children is federally mandated, Medicaid reimbursement for adult dental services is not required. Currently, States have increased pressure to eliminate optional Medicaid benefits in order to balance their annual budgets. In FY 2003, eight States were forced to reduce or eliminate

adult dental benefits.⁷⁴ These cuts do not come without an associated price, however. When Maryland eliminated adult dental reimbursement in 1993 there was a significant increase in the number of Medicaid eligible adults receiving costly dental care in hospital emergency departments.⁷⁵

Oral Health Research

It is clear that an informed policy response to the low oral health status in rural areas will require adequate health services research information. The NIH National Institute of Dental and Craniofacial Research and the Agency for Healthcare Research and Quality sponsor oral health and oral health services research with direct relevance to Federal policymaking. In addition, Rural Health Research Centers, funded by ORHP, have conducted some rural oral health care studies. The National Center for Health Workforce Analysis, sponsored by HRSA's Bureau of Health Professions, and its affiliated Regional Centers for Health Workforce. Studies also provide some important research information regarding the adequacy of the oral health workforce. In light of the alarming rural oral health disparities highlighted in this report, the Committee feels strongly that further research is necessary to identify the factors resulting in these disparities.

Publications and Reports

Finally, the potential of the Federal government to influence policy through the production and dissemination of reports and calls to action should not be underestimated. The Surgeon General's 2000 report *Oral Health in America* focused attention on the immediate need to improve access to oral health care in the United States. The CDC's *Healthy People 2010* reports on the current American health status and offers measurable objectives for its improvement. *Healthy People 2010* contains 17 separate objectives for strengthening oral health care in the U.S.

In 2003, U.S. Surgeon General Richard Carmona issued a Call to Action that reiterated the findings of the 2000 report and advocated a renewed commitment from public and private enterprises to continue working to improve oral health care and to eliminate barriers to

access. As the movement to improve dental services gains strength, it will be important for the Federal government to remain committed to this critical issue.

Conclusion

The magnitude of the oral health disparities that exist among broad segments of the U.S. population can be difficult to measure, particularly among rural residents. The Committee has detailed some of the existing disparities and highlighted certain policies that are in place to combat them. Writing a report is not enough, though. Echoing the Surgeon General's 2003 Call to Action, the Committee calls for an aggressive implementation of an HHS oral health initiative. Modeled after the Secretary's Rural Initiative, this effort would bring together all HHS operational and staff divisions in order to work collaboratively to develop a comprehensive action plan to improve the nation's oral health. In order to build support for this issue, the Committee urges the Secretary to convene an oral health summit with all key national organizations and attempt to develop a national oral health promotion strategy. The evidence indicating that the United States has an oral health problem is overwhelming. It is now time to draw on current information and formulate appropriately funded evidence-based policies that will extend access to oral health care to all Americans, regardless of their income, race, or geographic location.

Recommendations

- The Secretary, under Title XIX of the Social Security Act, should authorize a five to 10 percent increase in Federal matching funds for oral health services. This increased match would encourage States to expand dental coverage and provide dental reimbursements at a level sufficient to attract additional providers to the Medicaid program.
- The Secretary should work with the Office of Management and Budget (OMB) and Congress to seek increased funding for the Quentin N. Burdick Program for Rural Interdisciplinary Training, authorized by Title VII section 754 of the Public Health Service Act. Priority should be given to Quentin N. Burdick applicants whose programs include dentists or dental hygienists. The Secretary should also attempt to obtain more funding for the Health Careers Opportunity Program (HCOP) and Centers for Excellence (COE) Program, authorized by Title VII, sections 739 and 736, respectively. The additional funds should be used to increase the number of dental schools receiving HCOP and COE grants. This would provide more support for dental schools that seek to recruit additional minority and disadvantaged individuals and to expose students to practice opportunities in underserved communities.
- The Secretary should ensure adequate funding for the National Health Service Corps under Section 331 of the Public Health Service Act and should encourage it to pursue innovative strategies that will attract more dentists and dental hygienists to take part in the program.
- The Secretary should work with OMB to seek additional funding for the recruitment and loan repayment of Indian Health Service dentists and hygienists and to ensure that IHS dental facilities and equipment are adequate to meet the demand for services.
- The Secretary should work with OMB and the Congress to explore the establishment of a new categorical grant program that would provide funding to States for the fluoridation of small community water supplies and provide ongoing technical assistance and maintenance for such systems.
- The Secretary should work with Congress and OMB to establish a Federal-State partnership that is modeled after the State Offices of Rural Health Grant Program. This partnership would support the establishment of State Dental Offices with full-time directors in all 50 States and U.S. territories. Since the majority of oral health policy issues are under State jurisdiction, it is important to ensure that States have an adequate infrastructure to address pressing oral health issues and coordinate Statewide oral health initiatives.
- The Secretary should direct the National Institute for Dental and Craniofacial Research and the Agency for Healthcare Research and Quality to conduct a series

of studies on rural oral health disparities. These studies will provide additional information on the oral health status of rural residents and will provide critical information that will be used to guide evidence-based policymaking.

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Serving the Rural Elderly

This Committee has previously examined some of the challenges faced by the Medicare program in serving rural America (“Medicare Reform: A Rural Perspective,” 2001). This chapter, however, will focus on the human service side of serving the elderly. As such, it represents the Committee’s first examination of a human service issue since the expansion of its charter to include the integration of human services.

Background

The population of rural America, like elsewhere in the United States, is becoming older.

Currently, 25 percent¹ of all elderly (defined by the Census Bureau as persons 65 years or older) in the U.S. live in rural areas. The aging of the Baby Boom population will significantly increase the percentage of elderly in the country. In fact, more than 82 percent of the growth in expenditures for States is attributable to the care of the aged and disabled.²

From a demographic standpoint, rural elderly are becoming more isolated. The rural elderly population is scattered over 80 percent of the nation’s landmass.³ The proportion of elderly in rural counties (14.7 percent) is higher than in urban (11.0 percent) areas primarily due to the trend of young people migrating to larger urban areas. This out-migration, combined with low immigration rates, has resulted in an older population base, especially in the Great Plains and in the more remote rural counties that are agriculture-dependent.⁴ Population loss also occurred in low-income rural areas, such as the Appalachian coalfields and the lower Mississippi Valley.⁵

When rural young people move to urban areas, those who remain are, naturally, older residents. If, at the same time, retired people move in, the community effectively ages more rapidly.⁶ Retirement communities, primarily in coastal regions, experienced a rate of total population increase of 28.4 percent from 1990 to 2000.⁷ There was a rapid growth of the older population moving to the rural areas of the West and Mid-Atlantic regions,

mainly for retirement. However, the growth of the older population slowed or stopped in many areas in the Great Plains, Corn Belt, and lower Mississippi Delta.⁸

While retiree migration does increase populations and local tax bases, studies find that it does not increase per capita income, nor contribute to increased economic stability.⁹ Retirees who migrate tend to volunteer, rather than demand wage-paying jobs. In general, they are likely to be better educated than the average older person and also more aware of the programs and services available to them.¹⁰ They also tend to give little pressure to their adoptive communities to increase the provision of elderly services. When members of this population age and their needs increase, because of their limited ties to the community, they may move back to urban areas to be closer to their adult children or to health and social services.¹¹

These migration trends are important because where a person lives often has a strong impact on their health status. For instance, older rural residents are more likely to have poorer health and certain chronic conditions than their urban counterparts. Possible reasons for this disparity may be that the rural elderly tend to be less educated and earn lower incomes. Rural areas with a high proportion of elderly but without an influx of retirees

Facts About the Elderly

- The percent of the nation’s population 65 years and older was 8.9 in 1950. By 2000 the percentage was 12.4.¹²
- It is projected that by 2050 more than 20 percent of the nation’s population will be elderly.¹³
- Between 1990 and 2000 the elderly population nationally grew by 12 percent. Increases are expected to be greatest in the cohort, “oldest old” (85+).¹⁴

will be disadvantaged from the declining population and tax base.¹⁵ This hinders the ability of the community to provide necessary services, such as health care, housing and transportation.

The rural elderly face many of the same challenges as their urban counterparts in gaining access to services and maintaining independent lives. The demographic and socio-economic challenges inherent in this population, however, make these challenges much more difficult to overcome. For instance, the poverty rate, which ranges from 12.8 percent for counties adjacent to a metro area with populations above 20,000 to 20.6 percent for nonadjacent, completely rural counties, increases among older persons residing in areas of greater rurality.¹⁶ Rural elderly are more likely to live in poverty than their urban counterparts, 12.4 percent compared to 9.1 percent.¹⁷ In addition, 15 percent of people living in rural areas and only 11.2 percent of those in urban areas receive Medicaid.¹⁸

Rural elderly are poorer, in part, because rural employment is generally less available and more seasonal. In addition, the wage scale in rural areas is lower.¹⁹ The pattern of lower income among rural elderly is continuing with non-farm elderly, older women and the single elderly being the most disadvantaged. Only approximately 20 percent of rural elderly receive income from continued workforce activity.²⁰

In terms of lifestyle, the rural elderly are more likely to own their own homes, but the homes are of lesser value and in poorer condition than those owned by their urban peers. They are also more likely to be married and living with their spouse. Seventy-one percent of rural elderly were married in 1993, compared to 66 percent of urban elderly. However, by age 75 the likelihood of living alone was higher among rural elderly.²¹

Challenges

Significant challenges face policy makers and service providers who care for the elderly in rural America. The care, well-being and quality of life of rural elders is impaired by such issues as lack of nearby younger family members, difficulty accessing transportation²² and distances to services in rural communities. Rural areas lack many social and health services that would be considered “standard” in an urban/suburban setting. Other

The Rural Elderly and Health Status

- Nationwide, there are 1.6 million elderly in nursing homes.
- In rural areas there are more nursing home beds per 1,000 people (66.7) than in urban areas (51.9). This is due, in part, to the presence of fewer home and community-based services in rural areas.²³
- The elderly represent 12.3 percent of all hospital discharges.
- Elderly patients spend an average of six days in the hospital.
- More rural elderly (10.1 percent) receive Medicaid than urban elderly (8.2 percent).
- Older adults make up 10.2 percent of Medicaid recipients but account for more than 27 percent of program expenditures.²⁴
- More than 34 percent of elderly have limited ability to perform their normal daily activities.
- Close to 40 percent of the elderly report that they are in excellent or good health. However, the proportion of rural residents reporting fair to poor physical health is almost one and one half times that of urban residents.²⁵

important barriers are lack of knowledge of available services, continuous poverty, dwindling funding due to State budget crises, a limited number of senior centers and a shortage of qualified workers who offer services to the elderly.

Health insurance eligibility and coverage policies continue to prove confusing to even the most sophisticated policy makers, let alone any individual rural elder. Due to lack of economies of scale it is simply more expensive to provide services to rural areas. Finally, while the elderly, through the AARP, have long had a

strong global political voice, that organization has not focused on rural issues. In most cases, the rural elderly are just one of a number of sub-populations with special challenges among the larger elderly population and little attention has been paid to their specific needs.

Infrastructure

The first and most serious difficulty in providing health and human services for the elderly in rural America is the increasing fragility of the infrastructure in terms of both physical plant and personnel. Reimbursement and other policies have reduced both the number of and services provided by hospitals across the country. In the Committee's past work on Medicare reform, it has noted that medical schools are training fewer students in general medicine and that specialization of health care providers is an urban phenomenon. Increasingly, high-tech medicine requires highly trained personnel who are usually too expensive for a small rural hospital. There are also distinct challenges for human service workers serving rural elderly. In-home social services (adult day care, respite care, meals on wheels, for example) are much less likely to be available to rural residents.²⁶ Rural areas struggle to find qualified so-

cial workers, caseworkers, gerontologists and program directors. These professions are critical to meet the staffing needs of the rural elderly and the programs that serve them.

This situation is compounded by the economic state of many rural communities, which often are unable to fund adequate services. Government support, both at the Federal and State levels, is either being reduced or level-funded for social, health and welfare services. Local programs, faced with an aging population, are asked to serve more constituents.

For any elderly person, the continuity of care and the consistent availability of services are critical to maintaining independence. Seniors trust that services will be there for them from month to month, one year to the next. The vagaries of the funding streams for services, combined with the economic realities of rural areas that push many workers toward higher paying jobs in urban locales, create a situation in which a once-provided service may not exist the next time the elderly resident goes to use it. The spiral continues. As trust declines, fewer seniors look for services, and providers have fewer clients, which makes justification for increased, or even level funding, difficult.

The isolation of rural communities is a constant bar-

State Steps In to Support Meals Program

When the Roane County Committee on Aging, which provides senior services in the rural mountain community of Spencer, West Virginia, faced budget shortfalls in recent years, it turned to a different source of funding – the State lottery.

Lottery funds for senior services have been available in West Virginia since 1996 through the Legislative Initiatives for the Elderly (LIFE) program. The money is used by community agencies to provide meals, transportation, and other supportive and protective services, including senior centers. In 2001, the LIFE program served 16,529 persons, an increase of nearly 5,000 people since the year before.

The Spencer Senior Center is part of the Roane County Committee on Aging (RCCOA), which operates four senior centers and provides a variety

of services including transportation, home health care and daily lunches. Funding is based on projected services needed, so, if RCCOA serves more seniors than expected or does a better job of outreach, there is no way to cover the extra costs. This was the case with the nutrition program, which went from serving 700 meals in October 2002 to 1,600 meals in October 2003 – an increase partly attributable to the extensive telephone outreach program also operated by RCCOA. Consequently, the growth in the nutrition program also resulted in a \$38,000 deficit. Because Federal funding for nutrition services have been level for several years, paying for less than 20 percent of the expenses to senior programs, RCCOA has used LIFE funding to pay for its budget shortfall.

rier to rural service provision. As is discussed later, transportation options are extremely limited in rural areas, with few communities offering any type of public transportation system. Small towns are gradually stripped of local merchants and service providers as regional shopping centers and service complexes are built. Increasing travel distances are a hardship for the elderly. Isolation is also a reason that rural areas have trouble recruiting and retaining professionals in health and human services.

In addition, there is an undeniable link between health status and human services for the elderly. The goal of all the services directed toward the elderly is to improve the quality of life either through maintaining their independent living status or making those living in nursing homes and assisted living centers as viable and as independent as possible. As the rural elderly age, however, the ability to achieve that goal of independence can be hindered by declining health conditions. Incidences of Alzheimer's Disease, Parkinson's Disease and dementia present serious service challenges for all those who serve the elderly. Often times these illnesses and conditions hinder the elderly from obtaining services due to the diminished capacity of those individuals affected. For example, apathy is one of the earliest symptoms of Alzheimer's Disease and depression. Early dementia is unlikely to be perceived by the typical patient because she or he has lost the capacity for such an abstract thought as needing help, let alone the ability to obtain it.²⁷ Similarly, many illnesses of the elderly include symptoms of diminished mental vitality, lessening the ability of the individual to seek care. It is known that rural elders receive fewer home health care services and are more likely to be hospitalized than urban elderly.²⁸

Transportation

The lack of transportation options increases the isolation of rural elderly. Forty percent of rural residents live in areas with no public transportation system, 80 percent of rural counties have no public bus service, and, though the automobile is the only mode of transportation, 57 percent of rural residents do not own a car.²⁹ Thus, rural elderly are dependent on family members, friends, and neighbors for transportation. Taxis are an alternative for some, more financially secure, rural elderly, but not every town has them.

United We Ride Campaign Highlights Transportation Needs

Transportation problems have long plagued rural communities, but some help may be on the way thanks to the actions of four Federal agencies and a host of other participants.

In December of 2003, the U.S. Department of Transportation, in cooperation with the Departments of Health and Human Services, Labor and Education unveiled United We Ride, a five-part initiative that focuses on transportation needs for human services that includes the following:

- **A Framework for Action:** This publication is a self-assessment tool for States and communities to highlight successful models and identify next steps to improve coordination of human service transportation.
- **State Leadership Awards:** These awards will recognize a select number of States that have developed successful models in human service transportation coordination.
- **National Leadership Forum:** This National Conference will be held early in 2004 to bring together Governor-appointed senior leadership teams to raise the visibility of the transportation issue and provide technical assistance to policymakers.
- **State Coordination Grants:** States who participate in the United We Ride National Leadership Forum will be eligible to apply for these grants to address gaps and needs in human service transportation.
- **Help Along the Way:** A technical assistance program to help States and communities in the development and delivery of coordinated human services transportation programs.

For more information, go to: http://www.fta.dot.gov/CCAM/United_We_Ride.html

In general, government transportation programs are designed for urban areas. The transportation objectives in an urban area are vastly different than those in a rural community. The geographic distances are greater, and the volume of passengers is less in rural areas, which makes public transportation systems poor investments from a purely economic perspective. The difficulties in accessing transportation and distances that must be covered to services in rural communities are only two of the realities that make rural health and human services delivery challenging.

Some Federal funding for transportation services is available through the Older American's Act (OAA) Title IIIB Supportive Services. These funds are used primarily for trips to meal sites and medical facilities. These programs vie with case management, daycare, in-home care, information and assistance, and nutrition services, all within the same budget.

State budgets are in crisis across the nation resulting in, among many other things, a steady loss of public transportation services. The reality is that many Area Agency on Aging (AAA) programs and the communities they serve have to do more with less, which puts a priority on collaboration. The Committee urges all Federal agencies that provide services to the rural elderly to provide the needed flexibility that allows different service providers from across the spectrum to work together to develop innovative approaches to improving transportation. In many cases, this may mean sharing vehicles and reaching across programmatic lines.

Workforce

Decreasing numbers of qualified health and human service workers is a national concern. In rural areas the problem is exacerbated. This Committee reported in 2000 that approximately 10 percent of physicians practiced in rural areas while about 20 percent of the population lives in these areas.^{30,31}

The workforce challenges are no less daunting on the human service side. Nationally, elderly programs face difficulty attracting and retaining the gerontologists, social workers, administrators and caseworkers needed to offer high quality services. The challenge is only magnified in rural communities. Given the coming demographic challenges caused by the aging of the Baby Boom population, the need to train and deploy the

workforce that can meet the coming demand for services is paramount.

The health and human service infrastructures are much worse in rural areas, making rural recruitment and retention much more difficult. Lower salaries, out-dated equipment, scope of practice strains, geographic isolation, limited continuing educational opportunities, and fewer choices of schools and recreation activities all make working in a rural community less than inviting for many health and human service providers.

At the same time, residents of rural communities value both independence and communal support.³² Care is usually provided by a spouse or other close relative, often because formal healthcare and other services are not available. Volunteers have provided many needed human and health-related services in the past, but the modern demands of work and family often leave younger rural residents with little time for extensive volunteering.

There has been some Federal recognition of the important role played by families and volunteers, however. The National Family Caregiver Support Program (NFCSP), which was authorized by the Older Americans Act of 2000, is based largely on other, successful support programs.

The elderly face another workforce challenge separate and apart from service delivery. As the population ages and life expectancy grows, notions about when and if people should retire are changing. Already, many seniors are working much later in their lives. In part this is driven by economics as many seniors are working to support themselves financially. In rural areas, the Committee is concerned that there are more limited opportunities to continue working later in life. As a result, there may need to be targeted programs for workforce training and transportation needed to help seniors who want to work continue to do so.

The Federal Response

The challenge of providing needed services to this growing segment of the population is daunting, but even more so in rural areas given the lack of infrastructure, geographic isolation, and higher rates of poverty and chronic illness. This creates significant challenges for those programs within the Department of Health and Human Services (HHS) that seek to serve the elderly.

Aging and Disability Resource Center Grant Program

The Aging and Disability Resource Center Grant Program is part of the President's New Freedom Initiative, which aims to overcome barriers to community living for people with disabilities of all ages.

The Aging and Disability Resource Center Grant Program, a cooperative effort of the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS), was developed to assist States in their efforts to create a single, coordinated system of information and access for all persons seeking long-term support to minimize confusion, enhance individual choice and support informed decision-making. Health and Human Services Secretary Tommy G. Thompson announced the award of twelve grants in FY 2003 totaling \$9.26 to support State efforts to develop Aging and Disability Resource Centers, including some awards that went to predominantly rural states. Grants were awarded to the following States:

Louisiana
Maine
Maryland
Massachusetts
Minnesota
Montana
New Hampshire
New Jersey
Pennsylvania
Rhode Island
South Carolina
West Virginia

The HHS agencies with the primary responsibility for these services are the Administration on Aging (AoA) and the Administration on Children and Families (ACF). Other agencies such as CMS along with the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control

(CDC) also administer programs that provide a wide range of services to the elderly. Those agencies, however, focus primarily on health issues. This chapter will examine the human services provided by those agencies to the elderly.

The AoA Role

The Administration on Aging was established in 1965 through the enactment of the Older Americans Act (OAA). The OAA focuses particularly on vulnerable elderly who are at risk of losing their independence. There are also 15 programs under the Act in Title IIIB and IIIC that focus on nutrition and supportive services programs. The AoA encourages targeting of program services to minority, low-income and rural families. Of the 32 grants made to States in FY 2003, all but four specifically cover rural clients. In general, AoA programs target services to "older individuals with greatest economic need and older individuals' social needs, with particular attention to low-income minority individuals and older individuals residing in rural³³ areas."³⁴

For the past few years, AoA has noted the challenges of serving isolated rural elderly in both its budget documents and its submission for the Government Performance and Results Act (GPRA). The GPRA submission for FY 2002 shows that the AoA's Aging Networks successfully identified vulnerable elderly individuals, including the poor, minorities and individuals from rural areas.

AoA programs include the following:

* AoA's **Aging Network** consists of 56 State units on aging and 655 **Area Agency on Aging (AAA)** programs. AAAs provide local level program planning and development of home and community-based long-term care, in keeping with the OAA. Significant partners include 335 tribal organizations and thousands of service providers across the nation. The AAAs plan, coordinate and offer services such as Meals-on-Wheels, homemaker assistance and other programs to make independent living a viable option for older adults who wish to remain in their home. The services available through the AAAs fall into five broad categories: information and access services, community-based services, in-home services, housing and elder rights. Many AAAs rely on volunteers, who play a key support role

Declining Numbers in AoA Programs

Although AoA's programs are satisfying the mandate of the Older American's Act, the number of rural elderly participating is declining. Experts do not see this as a decline in need. Rather, many AAAs face difficulty in getting the word out about available services and meeting current needs in rural communities given resource and transportation barriers, which have been discussed in greater detail in other parts of this chapter.

In FY 1998, 33.5 percent of clients served by AoA programs were rural elderly. By 2000 the percentage had dropped to 32.9 and in FY 2001 the figure slid to 30.4 percent. This decline could be attributed to various factors. First, funding for programs created in the Older American's Act has been level for approximately 10 years. Second, as the elderly population increases, costs to agencies to provide the services mandated have increased over the decade. Cost increases have resulted in the creation of waiting lists for services. Other factors contributing to the decline in participation of rural elderly in AoA programs are the out-migration of health maintenance programs throughout rural America. Finally, some of the apparent decrease in participation can be attributed to the increasing

accuracy of reporting efforts. Some advocates have pointed out that this last phenomenon may continue given the new emphasis on rural health and human services by the Secretary.

The Committee is not sure which factors are actually responsible for declining participation in AoA programs, but the decline in the numbers of elderly served in rural areas requires further examination. Clearly, the Committee believes that the Department, States and local AAAs in rural communities would benefit from a major marketing effort to inform seniors about the services that are available to them. The Department has initiated a large-scale public education campaign for seniors about Medicare. The Committee believes a similar effort to inform seniors about the human service options available may help address the problem of declining numbers cited by the AoA.

The AoA has just completed a five-year strategic plan in which the first goal is to increase the percentage of OAA clients who live in rural areas to 35 percent by FY 2007.³⁵ The expectation is that AoA over time should serve a higher percentage of elderly persons in rural areas than the percentage in the total population.

in service provision but are not a substitute for professional staffing.

* In FY 2000 the OAA began the **National Family Caregivers Support Program**, which provides caregivers and grandparents raising grandchildren additional funds to support activities related to care giving. The NFCSP is designed to provide grants to States to support a continuum of caregiver services. These needs may include, but are not limited to, information, assistance, individual counseling, support groups and training, respite, and supplemental services to family caregivers of persons age 60 and older and grandparents and relative caregivers of children not more than 18 years of age. According to AoA, States, Tribes and communities across the country are making significant progress in implementing the NFCSP and early find-

ings show that initial expectations have been greatly exceeded.³⁶

* AoA also administers the **Alzheimer's Disease Demonstration Grants (ADDG)** program. This program helps States support effective models of care for persons with Alzheimer's disease. The ADDG program, which is authorized by Section 398 of the Public Health Services (PHS) Act, mandates the provision of the following support services: respite care, home health, personal care, companion care, day care, legal rights education, and information and counseling.

Planners of rural aging programs and support services confront unique barriers that impede access to services and limit choices of service professionals and provider organizations. Often, the rural AAA becomes the direct provider and/or sponsoring partner in the devel-

opment of housing and home and community-based long-term care systems. Established rural residents, retirees and nursing home residents transitioning back into their communities share in the desire for affordable and accessible housing, assisted living and medical care. AoA programs attempt to prevent institutionalization and loss of independence for as long as possible. In focusing on rural elderly, the AoA recognizes that rural residents are particularly vulnerable due to limited access to care and long distances to services compounded by limited community resources.

The ACF Role

The ACF is responsible for Federal programs that promote the economic and social well-being of families, children, individuals and communities. As such, its programs are not specifically focused on the elderly. However, given the broad focus of the wide array of ACF programs, these services have an important effect on the elderly.

The ACF Office of Community Services administers the Community Services Block Grant, which supports Community Action Agencies (CAA). This nationwide network leverages Federal, State and local funding to provide a wide range of services either through direct provision or contract relationship. Activities of the CAAs include Meals-on-Wheels, elder care, transportation services and employment guidance and training. The CAAs are locally run and design programs to meet their community's needs. CAAs serve approximately 10 million low-income people yearly and leverage nearly \$7 billion a year from all sectors to provide support, services, facilities and improvements in low-income communities. In some places in the U.S., the CAA is also the home of the Area Agency on Aging (AAA). As a result, the ACF and AoA programs are often tightly linked at the local level.

Conclusion

Rural elderly lack many of the same services that their urban and suburban counterparts take for granted. They often face greater distances to services, less knowledge of available services, or absence of services all together. Rural elderly also are more likely to live in poverty, to

lack access to transportation, and to live amid an older population than elders in other parts of the country.

The Committee is prepared to assist the Secretary in exploring ways in which the Federal government can better serve its rural elderly. It is clear that little is known about how the Department's programs serve this population. The Committee believes more research and analysis is needed to understand the unique challenges of serving the rural elderly and to determine if current programs are meeting those needs.

The Committee also believes one of the primary challenges facing rural seniors is their not being aware of available services. Quite frankly, there is a rural information gap. The creation in FY 2002 of the Rural Assistance Center (RAC) provided a conceptual point of entry for rural residents to learn about those programs supported by the Department. The Committee believes that the RAC may offer an opportunity to educate rural seniors about the full range of human service options. However, that alone is not enough to address the rural information gap. The Department should work with State and local communities to increase marketing efforts in rural communities that will make seniors aware of available services.

The Department can also play a critical role in bringing attention to the most pressing issues facing rural communities. During its site visits in the past year, the Committee was made aware that no issue facing rural seniors was more pressing than transportation. The Committee urges the Secretary to work with State and local leaders to identify options for better coordination of transportation services in rural communities. For example, school buses often sit idle on the weekends and during parts of the days. The Committee believes this offers an opportunity for sharing a local resource to better meet the needs of both school children and rural seniors. The buses could be used to bring seniors to needed services in rural communities in those times when they are not being used by the school system. The Committee recognizes, however, that this is an issue that is under the purview of the State and local jurisdictions. However, the Secretary and the Department could work in partnership with State and local leaders to see if there are programs that are willing share their transportation resources.

The Committee also believes that rural communities may be unique incubators for innovative projects that

link health and human service providers who serve rural seniors. Too often, funding streams, regulatory barriers and turf battles get in the way of innovation. However, given the coming challenge as the Baby Boom population ages, there is a need to test new ideas and solutions. Rural communities, where the resources are the most strained, may be the best place to try new ideas. For example, the Committee has heard from rural Area Agency on Aging programs that they need more flexibility in determining how many meals can be delivered through home delivery as opposed to congregate meals. Given the geographic isolation in rural communities, there is often a need to rely more heavily on home delivered meals than in urban areas, but some rural AAAs noted that there are restrictions that limit their ability to do so. The Committee believes the Department would benefit by looking at these and other regulations to determine if they are appropriate for service delivery to rural seniors.

Recommendations

- The Secretary should develop a demonstration project through Section 301 of the Public Health Service Act that would explore innovative approaches to providing transportation to rural elderly and would examine current Federal and State regulations and opportunities to use existing systems operated through Area Agency on Aging programs, Head Start and State and local transportation systems such as school buses.
- The Secretary should support research that examines how rural seniors access key services provided under the Older Americans Act to determine if there are any service gaps particular to rural communities.
- The Secretary should work with AoA to track expenditures in the National Family Caregivers Support Program to determine how much of the funding goes to rural communities.

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²⁰ *ibid.* Pg. 36.

²¹ Ham, “Best Practices.”

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³⁶ AoA FY 2004 Budget Submission.

Acronyms Used in this Report

AAA - Area Agency on Aging	NIH - National Institutes of Health
ACF - Administration for Children and Families	NOHSS - National Oral Health Surveillance System
AHEC - Area Health Education Center	OAA - Older Americans Act
AoA - Administration on Aging	OAT - Office for the Advancement of Telehealth
ASTDD - Association of State and Territorial Dental Directors	OMB - Office of Management and Budget
CAA - Community Action Agencies	ORHP - Office of Rural Health Policy
CAH - Critical Access Hospital	PHHS - Preventive Health and Health Services
CDC - Centers for Disease Control	PHS - Public Health Service
CMS - Centers for Medicare and Medicaid Services	RAC - Rural Assistance Center
COE - Centers for Excellence	RHC - rural health clinic
DHPSA - Dental Health Professional Shortage Area	RHEP - (West Virginia) Rural Health Education Partnership
DPU - distinct part unit	SAMHSA - Substance Abuse and Mental Health Services Administration
EPSDT - Early and Periodic Screening, Prevention, Diagnosis and Treatment	SCHIP - State Children's Health Insurance Program
FQHC - Federally Qualified Health Center	TANF - Temporary Assistance to Needy Families
GAO - General Accounting Office	UCR - usual customary rate
GPRA - Government Performance and Results Act	
HCOP - Health Careers Opportunity Program	
HHS - Department of Health and Human Services	
HPSA - health professional shortage area	
HRSA - Health Resources and Services Administration	
IHS - Indian Health Service	
MCHB - Maternal and Child Health Bureau	
MedPAC - Medicare Payment Advisory Commission	
MMA - Medicare Prescription Drug, Improvement Modernization Act	
MSA - metropolitan statistical area	
NACRHHS - National Advisory Committee on Rural Health and Human Services (also known as NAC)	
NFCSP - National Family Caregivers Support Program	
NHSC - National Health Service Corps	